PRINTED: 10/19/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	IPLE CONSTRUCTIONS	DN	(X3) DATE : COMPL	LETED
		495227	B, WING			1 10/0	05/2021
	ROVIDER OR SUPPLIER RT REHABILITATION A	ND NURSING CENTER		7300 FOREST A RICHMOND, V	VE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD IS-REFERENCED TO THE APPROPE DEFICIENCY)	86	(X5) COMPLETION DATE
E 000	Initiat Comments		E	000	<del>7 </del>		
E 037 SS=D	survey was conduct 10/5/2021. Correct compliance with 42 Requirement for Lo EP Training Prograt CFR(s): 483.73(d)(1). §403.748(d)(1). §445.441.184(d)(1). §485.485.68(d)(1). §485.68(d)(1). Training prograte following: (i) Initial training in opolicles and proced staff, individuals programagement, and vexpected roles. (ii) Provide emergelleast every 2 years. (iii) Maintain docum preparedness traini (iv) Demonstrate st procedures.	ng-Term Care Facilities.  1)  16.54(d)(1), §418.113(d)(1), §0.84(d)(1), §482.15(d)(1), §487.15(d)(1), §485.727(d)(1), §6.360(d)(1), §491.12(d)(1).  103.748, ASCs at §416.54, §6, ICF/IIDs at §483.475, HHAs nizations" under §485.727, RHC/FQHCs at §491.12:] m. The [facility] must do all of emergency preparedness ures to all new and existing oviding services under rotunteers, consistent with their noty preparedness training at the interpretation of all emergency ng. aff knowledge of emergency	E	conce immed 2. All sin-serv during requin docum accord 3. DO all nev prepa 4. DO 10% consum mand prepa identifi immed will be Assur	facility staff on duty at tirn was initiated received diate education. Staff not available at time vice previously initiated inspection received ed education and mentation completed dingly. Nor designee will education to designee will audit of current and new staff e compliance of receipt actory emergency redness training. Any fied issues will be diately corrected. Resulter the experied to Quality ance committee for analysision x 3 months. It is the diated to the compliance will be the of compliance will be the of compliance will be the complian	d le of le ate ency of lts	RECEIVE NOV 29 2021 VDH/OLO
	(v) If the emergency procedures are sign	y preparedness policies and nificantly updated, the [facility] ng on the updated policies and			N:		
	*[For Hospices at §	418.113(d):] (1) Training. The			52 124 124 - 124 - 124 - 124 - 124 - 124 - 124 - 124 - 124 - 124 - 124 - 124 - 124 - 124 - 124 - 124 -		
ARORATORY	DIRECTOR'S OR PROVIDE	RYSUPPLIER REPRESENTATIVE'S SIGNATU	RE	1 .	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: VA0270

	S FOR MEDICARE & DEFICIENCIES	MEDICAID SERVICES  [X1] PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		ATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	NG		С	
		495227	B. WING			10/05/2021	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP ( 7300 FOREST AVE RICHMOND, VA 23226	CODE		
(X4) ID PREFIX TAG	SUMMARY ST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
E 037	hospice must do all de (i) Initial training in e policies and procedu hospice employees, services under arrar expected roles. (ii) Demonstrate staff procedures. (iii) Provide emerger least every 2 years. (iv) Periodically revidemergency prepared employees (includin special emphasis planter procedures necessate others. (v) Maintain docume preparedness training (vi) If the emergency procedures are sign must conduct training procedures.  *[For PRTFs at §44 program. The PRTF (i) Initial training in policies and procedures staff, individuals programangement, and expected roles. (ii) After initial training procedures. (iii) Demonstrate staff procedures. (iv) Maintain docume preparedness training (vi) If the emergence of the emergence of the emergence of the emergence of the policies and procedures. (iv) Maintain docume preparedness training the emergence of the policies and procedures. (iv) Maintain docume preparedness training the emergence of the emergence of the emergence of the policies and procedures. (iv) Maintain docume preparedness training the emergence of the emergence of the policies and procedures. (iv) Maintain docume preparedness training the emergence of the emergence of the policies and procedures. (iv) Maintain docume preparedness training the emergence of the emergence of the policies and procedures. (iv) Maintain docume preparedness training the policies and procedures. (iv) If the emergence of the policies and procedures of the	of the following: mergency preparedness ares to all new and existing and individuals providing agement, consistent with their of knowledge of emergency ancy preparedness training at any and rehearse its dness plan with hospice ag nonemployee staff), with aced on carrying out the any to protect patients and antation of all emergency any preparedness policies and afficantly updated, the hospice ag on the updated policies and antation of all of the following: amergency preparedness ares to all new and existing aviding services under rolunteers, consistent with their ang, provide emergency ang every 2 years. aff knowledge of emergency mentation of all emergency	E	037	4. 25	RECEI NOV 29 VDH/(	

**FORM APPROVED** DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A, BUILDING \_ AND PLAN OF CORRECTION 10/05/2021 B. WING 495227 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7300 FOREST AVE WESTPORT REHABILITATION AND NURSING CENTER RICHMOND, VA 23226 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X4) ID CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG E 037 Continued From page 2 E 037 must conduct training on the updated policies and procedures. \*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. \*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency

\*[For CORFs at §485.68(d):](1) Training. The

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STATEMENT C	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION	CON	TE SURVEY MPLETED  C 0/05/2021	
	ROVIDER OR SUPPLIER	495227 ID NURSING CENTER	STRE 7300	ET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE HMOND, VA 23226			
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E 037	CORF must do all of (i) Provide initial train preparedness policie and existing staff, in- under arrangement, with their expected r (ii) Provide emergen least every 2 years. (iii) Maintain docume (iv) Demonstrate sta procedures. All new and assigned specif the CORF's emerge their first workday. I include instruction in alarm systems and equipment. (v) If the emergency procedures are sign must conduct trainin procedures.  *[For CAHs at §485 The CAH must do at (i) Initial training in a policies and procedure and where necess personnel, and gue cooperation with fir authorities, to all ne individuals providin and volunteers, con roles. (ii) Provide emerge least every 2 years (iii) Maintain docum	the following: ning in emergency as and procedures to all new dividuals providing services and volunteers, consistent toles. The preparedness training at entation of the training. If knowledge of emergency personnel must be oriented fic responsibilities regarding may plan within 2 weeks of the training program must in the location and use of signals and fireflighting  by preparedness policies and difficantly updated, the CORF ing on the updated policies and the following: emergency preparedness hures, including prompt guishing of fires, protection, any, evacuation of patients, sists, fire prevention, and defighting and disaster ew and existing staff, g services under arrangement, misistent with their expected ency preparedness training at	E 037			RECEIV Nov 29 2 VDH/O	1-2

PRINTED: 10/19/2021 FORM APPROVED

**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495227 B. WING 10/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE WESTPORT REHABILITATION AND NURSING CENTER RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 037 Continued From page 4 E 037 procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. \*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 vears. This REQUIREMENT is not met as evidenced Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documented evidence of annual emergency preparedness

training for the staff. The findings include:

The Emergency Preparedness Plan was reviewed with ASM (administrative staff member) #1, the administrator, on 10/4/2021 at 2:02 p.m. ASM #1 failed to provide evidence of annual emergency training for the five CNA (certified nursing assistants) employee records reviewed.

#3, the quality assurance and infection preventionist nurse, provided training documents

On 10/4/2021 at 4:17 p.m. RN (registered nurse)

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495227	B, WING		C
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE	10/05/2021
WESTPO	ORT REHABILITATION ANI	NURSING CENTER		RICHMOND, VA 23226	
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E 037	but these training documergency preparedness of the mergency preparedness of the mergency preparedness of the mergency preparedness of the computerized training have been assigned to #4 started employment 2021 as the staffing of the above concern of the above concern of the mergency preparedness of the mergency preparedness of the staffing of the mergency prepared to t	uments did not have less training.  flucted with RN #4, the 10/5/2021 at 9:36 a.m. e documentation of annual less training was, RN #4 e any to present. RN #4 ave access to the program where that would to the staff to complete. RN that the facility in March ducator.  If nursing, was made aware on 10/5/2021 at 1:58 p.m.	E 037		
F 000	An unannounced Med survey was conducted and 10/4/21 through 16 were investigated durin VA00053224, VA00052 VA00052261, and VA0 required for compliance	2620, VA00052665, 0052289. Corrections are a with the following 42 CFR Term Care requirements.	F 000		
SS=E	192 at the time of the s consisted of 60 current closed record reviews. Choose/Be Notified of ICFR(s): 483.10(e)(4)-(6)	certified bed facility was urvey. The survey sample resident reviews and 24 Room/Roommate Change 3)	F 559	#1. Residents #510, 29, 511, 512, 513 514, 516, 517, 515 are no longer residents in the center. Residents #11 153, 30, 75, 26, 66 and 13 have not participated in a room move since completion of ce inspection	ing 1, 139

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495227	B. WING		С
	PROVIDER OR SUPPLIER  ORT REHABILITATION AND		73	TREET AOORESS, CITY, STATE, ZIP CODE 100 FOREST AVE ICHMOND, VA 23226	10/05/2021
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	or her spouse when m same facility and both arrangement.  §483.10(e)(5) The right or her roommate of ch when both residents line both residents consent for esident's room or room changed.  This REQUIREMENT by:  Based on staff intervier review, clinical record racomplaint investigation the facility staff failed to the resident's room or room changed for eighteen or survey sample, (Reside #153, #30, #75, #26, ## #515, #13, #516, #517, The facility staff failed to notification for multiple provided to the resident	atried residents live in the spouses consent to the spouses consent to the state a room with his oice when practicable, we in the same facility and to the arrangement.  It to receive written notice, or the change, before the mate in the facility is is not met as evidenced as we facility document review, and in the course of on, it was determined that to provide written notice to ident representative, or the change, before the mate in the facility is facility is facility is facility is facility in the ents #510, #111, #29, #512, #66, #513, #139, #511, #514 and #383).  The evidence written room changes were representative and or #29, #153, #30, #75, #26, #515, #13, #516, #517,	F 559	2. All resident's participating in room moves since 09/01/2021 reviewed to ensur written notification provided for room chang.  3. DON or designee will education a facility staff on current policy for providing wontification to residents and/or response frepresentative prior to completion or change.  4. DON or designee will audit 10% or residents to ensure prior to complete room change, written notification was completed. Any identified issues will be immedia corrected. Results will be reported to Quality Assurance Committee for analysis a revision x 3 months.  5. Date of compliance will be	re pe.  Written possible of room  of all on of

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	IPLE CONSTRUCTION NG	<del></del>		E SURVEY PLETED C
		495227	B. WING	··· <u>·</u>		10	/05/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER	_	STREET ADDRESS, C 7300 FOREST AVE RICHMOND, VA 2	CITY, STATE, ZIP CODE		
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F 559	8/5/21.  Resident #510 was a 11/10/20 with diagnosstroke, diabetes, and recent MDS (minimur assessment with an Adate) of 8/13/21, Resbeing severely cognit daily decisions, havin the BIMS (brief intervwas coded as being land as sometimes understar	dmitted to the facility on ses including history of a deafness. On the most m data set), a quarterly ARD (assessment reference ident #510 was coded as rively impaired for making as scored zero out of 15 on item for mental status). He highly impaired for hearing, adderstood by others and	F	559			
	facility on 6/2/21, 6/3( On 9/29/21 at 4:30 p. notice of the room ch resident/RR (resident On 9/30/21 at 10:57 a member) #5, the adm interviewed. When as internal room transfe workers are in charge stated the social work who need a room cha once the change is of On 10/4/21 at 10:34 social services, was had only been workin days. She stated she	sferred to a new room in the b/21, 7/19/21, and 8/5/21.  Im., evidence of written ange provided to the trepresentative).  a.m., OSM (other staff hissions coordinator, was sked if she has a role in rs, she stated the social e of room transfers. She kers inform her of residents ange, and will inform her				u :	

DEPARTM	ENT OF HEALTHAI	SECURITION OF BUILDING				Olaibi	
		MEDICAID SERVICES	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DAT	re survey MPLETED
FATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDI				
ID PLAN OF	CORRECTION.					}	C
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		493221		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER			٦,	300 FOREST AVE		
	T REHABILITATION AN	NURSING CENTER			RICHMOND, VA 23225		
WESTPOR					1 PROVIDER'S PLAN OF CORR	ECTION	(X5)
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREF		I SOURCE ACTION SE	KOULD RE	COMPLETION
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]		0.9	F	559	){		ļ
F 559	Continued From pag	to a form the uses to					1
	work. She stated she	e has a form she uses to . She stated this should be a					1
	track room transfers.	. Sile stated this should be a					
	decision made by the	e team, and this team ocumented. She stated the					
	meeting should be d	be notified and told the					
	residenviols should be	er. OSM #4 stated she					
	orients the resident	to the new room, and			\		
	determines mom co	mpatibility. She stated she is					1
	required to documen	at everything she does to	1		<b>\</b>		
	notify a resident/RR	and to prepare the resident					1
	for a new room/room	nmate.					
	On 10/4/21 at 12:45	p.m., LPN (licensed practical					
	nurse) #10, a unit m	nanager, was interviewed. She			1		
	stated room change	es are managed by the social			]		1
	workers. LPN #10 s	stated, "They try to make sure red properly together."					1
	Me have beoble had	led properly together.			1		1
	On 10/4/21 at 3:39	p.m., ASM (administrative					
	stoff member) #2. t	he director of nursing, was				S - C *	
	intentiound She st	ated all rooms in the facility					
	are certified to hou	se residents with either private					
	how Madicare or N	Aedicald as payer sources.					ļ
	ASM #2 stated res	idents/RRs should be notified					
	of room changes, \$	She stated a room change is	ļ				ļ
	I usually promoted b	iv a resident request, an			į		1
	isolation requireme	ent, or a roommate issue. ASM					
	#2 stated there is t	Isually a conversation among					
	the team, and the	social worker is in charge of foocumenting the process. At					
l	the process, and o	was informed of the concerns	•		1		
	this time, ASM #2	insfers for this resident.					
	regarding room us	HIGHOLD TOL WILL THE TOTAL					
	On 10/4/21 at 5:06	3 p.m., ASM #1, the	-				
l	administrator Was	informed of these concerns.	1				
	Up stated the resi	dent should have had the			1		
1	accordingly to mer	et the new roommate and see			1		1
1	the new room AS	M #1 stated the reason for the			1		
	transfer should be	documented in the clinical					ion sheet Page 9

DEFARTI	VIEW OF THE ACTION	ALEDIAND SERVICES				OWR NO	. 0938-0391
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
AND PLAN OF	CORRECTION		7.00.20			(	
		495227	B, WING		<del></del>	10/	05/2021
	ROVIDER OR SUPPLIER	1		7:	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	COMPLETION DATE
F 559	Continued From page record, whether it be need.  A review of the facility Change/Roommate of the part: "Changes in room shall be made when necessary or when the change.  Policy Interpretation of the facility reserved to changes or room change of the sident requests the change/assignment all partice change/assignment representatives (spot (sic) hour/day advard.  Advance notice of include why the challinformation that will becoming acquainter roommate.  4. Unless medically and well-being of the be provided with an change. Such notice why the move is recombled.	patient choice or a clinical y policy, "Room Assignment," revealed, in om or roommate assignment the facility deems it he resident requests the and Implementation es the right to make resident ommate assignments when necessary or when the e change. a room or roommate	F	559			
	No further informati	on was provided prior to exit.					
	Complaint Deficience						
	2. The facility staff to notice of the room of #111and or the resi	ailed to evidence written change provided to Resident dent/RR (resident					post Page 10 of

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		NSTRUCTION			SURVEY PLETED
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		495227	B. WING				10	/05/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER		7300	ET ADDRESS, CITY, STATE, ZIP CO FOREST AVE IMOND, VA 23226	DOE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCE	ON SHOULD I 1E APPROPR	3E	(X5) COMPLETION DATE
F 559	representative) for ro 6/1/21, and 6/2/21.  Resident #111 was a 5/4/21 with diagnose chronic obstructive p disease), and Alzheit recent MDS (minimus assessment with an 4 date) of 8/28/21, Reshaving severe impair decisions, having scott BIMS (brief interview A review of the reside they were transferred on 5/25/21, 6/1/21, a 4:30 p.m., evidence change provided to trepresentative) was On 9/30/21 at 10:57 member) #5, the adrinterviewed. When a internal room transfer workers are in charg stated the social wor who need a room chonce the change is concentrated the social wor who need a room chonce the change is concentrated the social wor who have a fine transfer on the change is concentrated the social wor who have the stated short residents' room charwork. She stated short rack room transfers decision made by the	dmitted to the facility on sincluding a left hip fracture, ulmonary disease (lung mer's disease. On the most m data set), a quarterly ARD (assessment reference sident #111 was coded as ment for making daily ored seven out of 15 on the for mental status).  ent's clinical record revealed d to a new room in the facility and 6/2/21. On 9/29/21 at of written notice of the room the resident/RR (resident requested.  a.m., OSM (other staff missions coordinator, was sked if she has a role in the social e of room transfers. She kers inform her of residents ange, and will inform her	F	559				

DEFARIT	VIENT OF THE RETURN	MEDICAID SERVICES				UMB N	U. 0930-0391
	S FOR MEDICARE & DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION		E SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILD	ING			c
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		495227	B. WING				0/03/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER		7300	EET ADDRESS, CITY, STATE, ZIP CODE ) FOREST AVE HMOND, VA 23226		
11231101	_		100		PROVIDER'S PLAN OF CORRECT	non	(X5)
(X4) ID PREFIX TAG	ICACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREF	XI	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	COMPLÉTION DATE
	Continued From page resident/RR should be reason for the transfrorients the resident to determines room correquired to documen notify a resident/RR for a new room/room  On 10/4/21 at 12:45 nurse) #10, a unit me stated room changes workers. LPN #10 stowe have people pair  On 10/4/21 at 3:39 per staff member) #2, the interviewed. She stated reside of room changes. Susually prompted by isolation requirement #2 stated there is use the process, and of this time, ASM #2 we regarding room transfer.	e 11  be notified and told the er. OSM #4 stated she to the new room, and inpatibility. She stated she to the new room, and inpatibility. She stated she is at everything she does to and to prepare the resident timate.  p.m., LPN (licensed practical anager, was interviewed. She is are managed by the social ated, "They try to make sure ed properly together."  b.m., ASM (administrative the director of nursing, was atted all rooms in the facility eresidents with either private edicaid as payer sources. Stents/RRs should be notified the stated a room change is a resident request, an int, or a roommate issue. ASM sually a conversation among ocial worker is in charge of documenting the process. At as informed of the concerns affers for this resident.		559	DEFICIENCY		
	He stated the resid opportunity to meet the new room. ASM	ent should have had the the hew roommate and see if #1 stated the reason for the documented in the clinical se patient choice or a clinical					
1	No further informat	ion was provided prior to exit.					sheet Page 12 of

CENTERS		MEDICAID SERVICES	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					С
AND FOUTO.		50				1	0/05/2021
		495227	B. WING	_	STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	ROVIDER OR SUPPLIER				7300 FOREST AVE		
	T REHABILITATION AN	NURSING CENTER			RICHMOND, VA 23226		
WESTPOR			1 10	_	DOCUMENTS PLAN OF CORRECT	NOI	(X5) COMPLETION
(X4) ID PREFIX TAG	ALCOHOLD CONTRACT	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG	ΉX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	שט עטו	DATE
F 559	Continued From pag	e 12	F	55	9		
	Complaint Deficiency	•					
	notice of the room C	illed to evidence written nange provided to Resident presentative) for room , and 6/7/21.					
	10/28/20 with diagnormal and depression (minimum data set), an ARD (assessmer Resident #29 was compaired for making	dmitted to the facility on coses including an abdominal on. On the most recent MDS a quarterly assessment with a reference date) of 7/13/21, oded as being severely daily decisions, having 15 on the BIMS (brief status).					
	they were transferred on 5/27/21, and 6/7 evidence of written provided to the resignative).	dent's clinical record revealed to a new room in the facility 1/21. On 9/29/21 at 4:30 p.m., notice of the room change ident/RR (resident devidence orientation of the room/roommate was				RŰ	
	member) #5, the a interviewed. When internal room trans workers are in cha stated the social who need a room once the change i						
	cocial services W	34 a.m., OSM #4, the director of as interviewed. She stated she rking at the facility for three			Facility ID: VA0270	If continuation	n sheet Page 13 of

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				(X3) DATE	SURVEY
TATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1		CONSTRUCTION	COMP	LETED
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	MG		- (	3
		405027	B. WING			10/	05/2021
		495227	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1	00 FOREST AVE		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		RI	CHMOND, VA 23226		
			10	1	PROVIDER'S PLAN OF CORRECTI	ON	(X5) COMPLETION
(X4) ID	LEAGUI DESICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  THE PROPERTY OF THE PROPE	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	'	DEFICIENCY)		
			-				i
		40	F	559			
F 559		e 13	'				
	days. She stated she	could not speak to the					1
	residents' room char	nges before she started to has a form she uses to					
	work. She stated she	. She stated this should be a					
	track room transfers.	e team, and this team					
	meeting should be d	ocumented. She stated the					
	regident/RR should	be notified and told the	-				
	reason for the transf	fer. OSM #4 stated she			1		
	orients the resident	to the new room, and			1		1
	determines room co	mpatibility. She stated she is	l l				1
	required to documen	nt everything she does to					1
	notify a resident/RR	and to prepare the resident					
	for a new room/roor	nmate.					
	On 40/4/21 at 12:45	p.m., LPN (licensed practical					
	nurse\#10 a unit m	nanager, was interviewed. Sile	- 1				
	stated room change	es are managed by the social					
1	workers LPN #10 s	tated, "They try to make sure					
	we have people pai	red properly together."	3		£ \$0	Y.1	1 6
	1	ACM (administrative	-				
	On 10/4/21 at 3:39	p.m., ASM (administrative he director of nursing, was					
	starr member / #2, t	ated all rooms in the facility	1				
	are cortified to bout	se residents with either private	1				
]	Low Medicare or N	Medicaid as payer sources.	-				
	ASM #2 stated resi	idents/RRs should be notified					
l	of room changes. S	She stated a room change is	l				
ŀ	usually prompted b	iv a resident request, an	1				
	isolation requireme	ent, or a roommate issue. ASM					
	#2 stated there is u	isually a conversation among	1				
	the team, and the	social worker is in charge of	1				
	the process, and o	f documenting the process. At was informed of the concerns					
	this time, ASM #2	insfers for this resident.					
	regarding room tra	Highers for All A Lockson					
	On 10/4/21 at 5:06	6 p.m., ASM #1, the					
1	administrator, was	informed of these concerns.					
	He stated the resid	dent should have had the	ļ				
	opportunity to mee	et the new roommate and see			Facility ID: VA0270	Leastinustion	sheet Page 14

		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DINSTRUCTION		DATE SURVEY COMPLETED
l			495227	B, WING				10/05/2021
		ROVIDER OR SUPPLIER	ID NURSING CENTER		7300	ET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE HMOND, VA 23226		
	(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
	F 559	the new room, ASM transfer should be do record, whether it be need.  No further information Complaint Deficiency  4. The facility staff far notice of the room of the room of the room of transfers on 5/26/21, Resident #153 was a 2/11/21, and most rewith diagnoses incluings, bipolar disorder psychotic features, a disorder. On the most data set), a quarterly (assessment referen #153 was coded as impaired for making scored 12 out of 15 of the years transferre on 5/26/21, 6/2/21, a 4:30 p.m., evidence change provided to representative), and resident to the new requested.  On 9/30/21 at 10:57 member) #5, the ad interviewed. When a	#1 stated the reason for the ocumented in the clinical patient choice or a clinical mass provided prior to exit.  Whiled to evidence written the presentative) for room (6/2/21, and 9/11/21).  Admitted to the facility on executly readmitted on 3/12/21, ding paralysis of arms and ex with manic features, severe and post-traumatic stress st recent MDS (minimum y assessment with an ARD noe date) of 9/13/21, Resident being moderately cognitively daily decisions, having	F	559			RECEIV. NOV 29 202

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE COMP	SURVEY
				_		,	С
		495227	B. WING			10/	05/2021
	ROVIDER OR SUPPLIER RT REHABILITATION AND	NURSING CENTER		7:	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	workers are in charge stated the social work who need a room cha once the change is co On 10/4/21 at 10:34 a social services, was in had only been working days. She stated she residents' room chang work. She stated she track room transfers. Since the decision made by the meeting should be reason for the transfer orients the resident to determines room comprequired to document to determines room comprequired to document notify a resident/RR at for a new room/roomm On 10/4/21 at 12:45 p. nurse) #10, a unit mas stated room changes a workers. LPN #10 state we have people paired on 10/4/21 at 3:39 p.m staff member) #2, the dinterviewed. She state are certified to house reason changes. She usually prompted by a isolation requirement, we was stated there is usually groups at the stated there is usually groups was stated the was stated there is usually groups was stated the was stated there is usually groups was stated the was stated t	of room transfers. She ers inform her of residents nge, and will inform her mplete.  .m., OSM #4, the director of aterviewed. She stated she go at the facility for three could not speak to the es before she started to has a form she uses to She stated this should be a team, and this team cumented. She stated the cotified and told the . OSM #4 stated she the new room, and patibility. She stated she is everything she does to nd to prepare the resident hate.  m., LPN (licensed practical lager, was interviewed. She are managed by the social ed, "They try to make sure I properly together."  n., ASM (administrative director of nursing, was d all rooms in the facility esidents with either private icaid as payer sources. hts/RRs should be notified stated a room change is	F	559			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A, BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	ETED
		495227	B. WING			5/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULO BE	(X5) COMPLETION DATE
F 559	the process, and of of this time, ASM #2 waregarding room trans.  On 10/4/21 at 5:06 p administrator, was in He stated the reside opportunity to meet the new room. ASM transfer should be derecord, whether it be need.  No further information.  Complaint Deficiency.  5. The facility staff far notice of the room of #30/RR (resident reptransfers on 6/29/21.  Resident #30 was as 5/28/21 and most rewith diagnoses inclusively without behaviors, hobstructive pulmona the most recent MDS quarterly assessmen reference date) of 7/coded as being severaking daily decision of 15 on the BIMS.  A review of the residence on 6/29/21 and 8/20	locumenting the process. At as informed of the concerns ifers for this resident.  .m., ASM #1, the formed of these concerns. In the should have had the he new roommate and see #1 stated the reason for the commented in the clinical patient choice or a clinical patient choice or a clinical in was provided prior to exit.  If the provided to Resident presentative in the facility on contily readmitted on 8/20/21, dring a brain bleed, demential eart failure, and chronic ry disease (lung disease). On the provided the provided to the facility on the provided to a seen the provided to a new room in the facility /21, On 9/29/21 at 4:30 p.m., anotice of the room change	F 55			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
ANDFOR	CORRECTION	IDEATH JOAT JOH HOMOEN.	A. BUILD	ING.	<del></del>		
		495227	B. WING				C 05/2021
A1445 05 0	20/12/20 00 01/20/150	433221	5, 11,110	_	STREET ADDRESS, CITY, STATE, ZIP CODE	10/	03/2021
NAME OF PI	ROVIDER OR SUPPLIER			'			
WESTPOR	RT REHABILITATION AND	NURSING CENTER			7300 FOREST AVE		
				_ '	RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
			<u> </u>		DEFICIENCY)		
			1				
F 559	Continued From page	17	F	559			
	representative) was re	equested.					
			1				
	On 9/30/21 at 10:57 a	•					
İ	, .	issions coordinator, was					
ı		ked if she has a role in	1				
		s, she stated the social	1				
,		of room transfers. She					
		ers inform her of residents					
		nge, and will inform her	ł				
	once the change is co	implete.					
	On 10/4/21 at 10:24 a	.m., OSM #4, the director of					
i		nterviewed. She stated she					
-	* * * * * * * * * * * * * * * * * * * *	at the facility for three	1				
	days. She stated she	•					
	•	es before she started to					
1		has a form she uses to					
	track room transfers. S	She stated this should be a					
ľ	decision made by the	team, and this team					
	meeting should be doo	cumented. She stated the					1
	resident/RR should be	notified and told the			·		·
1	reason for the transfer	. OSM #4 stated she					
	orients the resident to	·					
		patibility. She stated she is	1				
		everything she does to					
	-	nd to prepare the resident					
	for a new room/roomn	nate.	1				
	On 10/4/21 at 12:45 a	.m., LPN (licensed practical			1		
	•	nager, was interviewed. She				į	
		are managed by the social					
		ed, "They try to make sure	Ī			j	
	we have people paired						
	· · · · · · · · · · · · · · · · · · ·						
	On 10/4/21 at 3:39 p.n	n., ASM (administrative					
- 1	•	director of nursing, was					
		d all rooms in the facility					
		esidents with either private					
	pay, Medicare, or Med	licaid as payer sources.	-		_		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	COM	PLETED
MAD LEVIA OL				_			С
		495227	B, WING			10	05/2021
NAME OF P	ROVIDER OR SUPPLIER	<u></u>		Sī	REET ADDRESS, CITY, STATE, ZIP CODE		
				73	100 FOREST AVE		
WESTPO	RT REHABILITATION AN	ID NURSING CENTER	RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	≬D PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 559			F	559			
	ASM #2 stated resid	ents/RRs should be notified					
	of room changes. Sh	e stated a room change is					
	usually prompted by	a resident request, an					
	isolation requiremen	t, or a roommate issue. ASM					
	#2 stated there is us	ually a conversation among					
	the team, and the so	cial worker is in charge of					
	the process, and of o	documenting the process. At					
	this time, ASM #2 Wi	as informed of the concerns					
	regarding room trans	sfers for this resident.					
	On 10/4/21 at 5:06 p	o.m., ASM #1, the					1
	administrator, was in	nformed of these concerns.					
	He stated the reside	nt should have had the					
	opportunity to meet	the new roommate and see					
	the new room. ASM	#1 stated the reason for the	1				1
	transfer should be d	ocumented in the clinical					
	record, whether it be	patient choice or a clinical					1
	need.	•					
19 19	No further information	on was provided prior to exit.	2.		1879 187	2	15
	Complaint Deficience						
	6. The facility staff fa	ailed to evidence written					
	notice of the room c	hange provided to Resident					
ļ	#75/RR (resident re	presentative) for room					
Ì	transfers on 6/3/21	and 7/22/21.					
	Decident #75 was a	dmitted to the facility on					
	1/23/20 with diagon	ses including a spinal injury					
1	and paranlegia (par	alysis of legs). On the most					
	recent MDS (minimu	um data set), an admission	ł				
	assessment with an	ARD (assessment reference					1
1	date) of 7/28/21, Re	esident #75 was coded as					
	being moderately co	ognitively impaired for making					
	daily decisions, hav	ing scored nine out of 15 on					
	the BIMS (brief inte	rview for mental status).					
	A review of the resid	dent's clinical record revealed			<u> </u>		

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	A, BUILDI		NSTRUCTION	1	PLETED C
		495227	B. WING			10/	/05/2 <u>021</u>
	ROVIDER OR SUPPLIER	D NURSING CENTER	160	7300 F	ET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE MOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
F 559	on 6/3/21 and 7/22/2/2 evidence of written no provided to the reside representative), and or resident to the new rorequested.  On 9/30/21 at 10:57 a member) #5, the adminterviewed. When as internal room transfer workers are in charge stated the social work who need a room charge stated the social work who need a room charge is compared to the change is compared to the change is compared to make the change is compared to make the change is compared to make the change is compared to make the change is compared to make the change is compared to the change is compared to the change is compared to the change is compared to the change is compared to the change is compared to the change is compared to the change is compared to the change is compared to the compar	to a new room in the facility 1. On 9/29/21 at 4:30 p.m., blice of the room change ant/RR (resident evidence orientation of the com/roommate was  a.m., OSM (other staff dissions coordinator, was sked if she has a role in s, she stated the social e of room transfers. She ters inform her of residents ange, and will inform her complete.  a.m., OSM #4, the director of anterviewed. She stated she g at the facility for three could not speak to the ges before she started to has a form she uses to She stated this should be a team, and this team commented. She stated the e notified and told the art OSM #4 stated she to the new room, and apatibility. She stated she is everything she does to and to prepare the resident	F	559			
	workers, LPN #10 sta we have people paire	ated, "They try to make sure ad properly together."					

	ENT OF REALTH AN	ACDIONID OF OMICES			Oiv	IB <u>NO. 0938-039</u>
	DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION	(X3	DATE SURVEY COMPLETED
		495227	B, WING			10/05/2021
	OVIDER OR SUPPLIER T REHABILITATION AN			STREET ADDRESS, CITY, ST 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	JEACH DESIGNATIONS	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Continued From page On 10/4/21 at 3:39 p. staff member) #2, the interviewed. She state are certified to house pay, Medicare, or Me ASM #2 stated reside of room changes. Sh usually prompted by isolation requirement #2 stated there is use the team, and the so the process, and of of this time, ASM #2 we regarding room trans On 10/4/21 at 5:06 p administrator, was in He stated the reside opportunity to meet the new room. ASM transfer should be d record, whether it be need.  No further information Complaint Deficience 7. The facility staff for notice of the room of #26/RR (resident re transfers on 7/18/21 Resident #26 was a 8/20/20 with a diage behaviors. On the re	e 20  Im., ASM (administrative director of nursing, was led all rooms in the facility residents with either private edicaid as payer sources. Ints/RRs should be notified the stated a room change is a resident request, and the conversation among lead worker is in charge of documenting the process. At as informed of the concerns afters for this resident.  Im., ASM #1, the informed of these concerns and should have had the the new roommate and see #1 stated the reason for the ocumented in the clinical expanding provided prior to exit.	F	559	DE MENOT	

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE C	ONSTRUCTION	(X3) DA	TE SURVEY MPLETED
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILD			1	
MIAD I CH. V.		·					C
		495227	B, WING				0/05/2021
	THE STATE OF CHIRDHER			STR	EET ADDRESS, CITY, STATE, ZIP COD	E	
	ROVIDER OR SUPPLIER			730	O FOREST AVE		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		RIC	:HMOND, VA 23226		
			ID		PROVIDER'S PLAN OF CO	RRECTION	(X5) COMPLETION
(X4) ID	(EACH DESICIENT	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	APPROPRIATE	DATE
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAC	3	DEFICIENCY)	_	
			10				
			1 -				
F 559	Continued From pag	e 21		559			
	coded as being seve	rely cognitively impaired for					
	making daily decision	ns, having scored zero out of					
	15 on the BIMS (brie	f interview for mental status).					
	İ			1			
	A review of the resid	ent's clinical record revealed	1	- 1			
	they were transferre	d to a new room in the facility		l			1
	on 7/18/21, and 7/19	/21. On 9/29/21 at 4:30 p.m.,		]			
	evidence of written r	notice of the room change					
	provided to the resid	envkk (resident					- 1
	representative).		3				
	0-0/20/21 01 10/57	a.m., OSM (other staff					
ĺ	On 9/30/21 at 10.5/	missions coordinator, was					l
	Intended When	isked if she has a role in	7.	1			
1	internal room transfe	ers, she stated the social					
	workers are in charg	ge of room transfers. She					
1	stated the social wo	rkers inform her of residents					
	who need a room cl	nange, and will inform her	1				
	once the change is	complete.				(4)	i
					*		
·	On 10/4/21 at 10:34	a.m., OSM #4, the director of					
	social services, was	interviewed. She stated she					1
	had only been work	ing at the facility for three					1
	days. She stated sh	ne could not speak to the					
	residents' room cha	nges before she started to he has a form she uses to					
-	work. She stated sh	s. She stated this should be a					
	track room transfers	s, She stated this should be a	- 1				
1	decision made by the	ne team, and this team documented. She stated the					ľ
	meeting should be	be notified and told the					
	residentikk snould	ifer. OSM #4 stated she	1				
	reason for the trans	to the new room, and					1
	orients the resident	ompatibility. She stated she is	1				
	determines found	ent everything she does to					
	notify a recident/DE	R and to prepare the resident					
	for a new room/roo	mmate.					
	1						Ì
1	On 10/4/21 at 12:4	5 p.m., LPN (licensed practical					
	nurse) #10. a unit	nanager, was interviewed. She					
	nursey ir ro, a diffic		D# 11	F	acility ID: VA0270	If continuation	sheet Page 22 of

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT C	S FOR MEDICARE & DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A, BUILDING	E CONSTRUCTION		TE SURVEY MPLETED
			D WING	_	1	0/05/2021
	ROVIDER OR SUPPLIER	495227  D NURSING CENTER		STREET ADDRESS, CITY, STATE. ZIP COU 7300 FOREST AVE RICHMOND, VA 23226	DÉ	
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 559	stated room changes workers. LPN #10 st we have people pair.  On 10/4/21 at 3:39 p staff member) #2, th interviewed. She sta are certified to house pay, Medicare, or M ASM #2 stated resid of room changes. Si usually prompted by isolation requiremer #2 stated there is us the process, and of this time. ASM #2 w	s are managed by the social ated, "They try to make sure ed properly together."  I.m., ASM (administrative e director of nursing, was ted all rooms in the facility e residents with either private edicaid as payer sources. ents/RRs should be notified no stated a room change is a resident request, an at, or a roommate issue. ASM sually a conversation among ocial worker is in charge of documenting the process. At was informed of the concerns seers for this resident.	F 55	9		
	He stated the reside opportunity to meet the new room. ASM transfer should be crecord, whether it be need.  No further information to complaint Deficient 8. The facility staff notice of the room #512/RR (resident transfers on 6/3/21	nformed of these concerns. ent should have had the the new roommate and see I #1 stated the reason for the documented in the clinical e patient choice or a clinical ion was provided prior to exit.  cy failed to evidence written change provided to Resident representative) for room and 6/5/21.				
	Resident #512 was 5/12/21, and most	admitted to the facility on recently readmitted on 7/9/21,			if continuation	sheet Page 23

STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X:	B) DATE SURVEY COMPLETED C
		495227	B, WING				10/05/2021
	ROVIDER OR SUPPLIER			7300	ET ADDRESS, CITY, STATE. ZIP CODE FOREST AVE IMOND, VA 23226		
(X4) ID PREFIX TAG	(CACH DESICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC   DENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 559	behaviors and sepsis the most recent MDS admission assessme reference date) of 5/2 coded as being seve dally decisions, having the BIMS (brief interview of the residence of 6/3/21 and 6/5/21 evidence of written in provided to the residence workers are in charge stated the social workers are in charge stated the social work who need a room chonce the change is of the charge is	ding dementia without (body-wide infection). On (minimum data set), an (mt with an ARD (assessment 18/21, Resident #512 was (rely impaired for making (ng scored three out of 15 on (riew for mental status).  ent's clinical record revealed (d to a new room in the facility (on 9/29/21 at 4:30 p.m., (otice of the room change ent/RR (resident requested.  a.m., OSM (other staff (missions coordinator, was (sked if she has a role in (ers, she stated the social (erse of room transfers. She (there inform her of residents (erse, and will inform her	F	559		150	

DENTERS FOR MEDICARE & MEDICAID SERVICES STREAM OF PROVIDER OR SUPPLIER MAYO PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND MURSING CENTER  WESTPORT REHABILITATION AND MURSING CENTER  SUMMARY STATEMENT OF SERVICES SER	DEPART	WENT OF TICHETTAN	ATTIONIS SERVICES				OWR NO	<u>. 0938-039</u>
MAY 25 SUMMARY STATEMENT OF DEFICIENCIES BLACK DEFICIENCY AND NURSING CENTER  WESTPORT REHABILITATION AND NURSING CENTER  PRIEFIX SUMMARY STATEMENT OF DEFICIENCIES BLACK DEFICIENCY MAY BE PRECEDED BY FULL TAG.  PRIEFIX BLACK DEFICIENCY MAYS BE PRECEDED BY FULL ADDRESS, CITY, STATE, ZIP CODE TO FOREST AVE.  REGULATORY OR LS CIDENTIFYING INFORMATION PRIEFIX BLACK OF CORRECTION COMPARITOR CENTER AND COMPARITOR CONTINUED.  F 559  Continued From page 24 notify a resident/IRR and to prepare the resident for a new room/room/ralate.  On 10/4/21 at 12.45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated. They fry to make sure we have people paired properly together.*  On 10/4/21 at 3.39 p.m., ASM (administrative staff member) #2, the director of rursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.  On 10/4/21 at 500 p.m., ASM #1, the administrator, was informed of the concerns regarding room transfers for this resident.  On 10/4/21 at 500 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room, ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.  No further information was provided prior to exit.  Complaint Deficiency  9. The facility staff failed to evidence written	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION		
MESTPORT REHABILITATION AND NURSING CENTER  WESTPORT REHABILITATION AND NURSING CENTER  PROVIDERS PLAN OF CORRECTION (REGULATORY OR LSC IDENTIFYING INFORMATION)  FIRST CONTINUED TO THE REGULATORY OR LSC IDENTIFYING INFORMATION)  F 559  Continued From page 24 notify a resident/RR and to prepare the resident for a new room/roommate.  On 10/4/21 at 12-45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They it to make sure we have people paired properly together."  On 10/4/21 at 3.39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated are omn change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a corresponding to the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.  On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the relational record, whether it be patient choice or a clinical record, whether it be patient choice or a clinical need.  No further information was provided prior to exit.  Complaint Deficiency  o The facility staff failed to evidence written	ANU PLAN OF	CORRECTION						
SAMARY STATEMENT OF DEPOCED BY PILL RECOLATORY ON LISC IDENTIFYING INFORMATION)  F 559  COntinued From page 24 notity a resident/RR and to prepare the resident for a new room/roommate.  On 10/4/21 at 12-45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, They try to make sure we have people paired properly together."  On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue, ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.  On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.  No further information was provided prior to exit. Complaint Deficiency  9. The facility staff falled to evidence written					7300	FOREST AVE		
on 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together."  On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of froom changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.  On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommade and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.  No further information was provided prior to exit.  Complaint Deficiency	PREFIX	/EACH DESIGIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP	DBE	COMPLETION
notice of the room change provided to Resident	F 559	notify a resident/RR a for a new room/room On 10/4/21 at 12:45 nurse) #10, a unit ma stated room changes workers. LPN #10 state we have people pairs On 10/4/21 at 3:39 p staff member) #2, the interviewed. She state are certified to house pay. Medicare, or Mr. ASM #2 stated resid of room changes. She usually prompted by isolation requiremen #2 stated there is us the team, and the softhe process, and of this time, ASM #2 w regarding room trans. On 10/4/21 at 5:06 p administrator, was in He stated the reside opportunity to meet the new room. ASM transfer should be direcord, whether it be need.  No further information.	and to prepare the resident mate.  p.m., LPN (licensed practical anager, was interviewed. She are managed by the social ated, "They try to make sure ed properly together."  m., ASM (administrative edirector of nursing, was ted all rooms in the facility eresidents with either private edicaid as payer sources. ents/RRs should be notified ne stated a room change is a resident request, an at, or a roommate issue. ASM sually a conversation among cial worker is in charge of documenting the process. At as informed of the concerns afters for this resident.  p.m., ASM #1, the informed of these concerns. The theology of the concerns are the concerns of the	F	559			

DEPART	MENT OF HEALTHAN	DITTO SERVICES				UMD N	O. 0930-0331
		MEDICAID SERVICES	OX21 MUII	TIPLE (	CONSTRUCTION		E SURVEY
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDI			COK	l.
AND PLAN OF	CORRECTION				<del></del> -	ŀ	c
		495227	B, WING			1	0/05/2021
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NAME OF PE	ROVIDER OR SUPPLIER			1	00 FOREST AVE		
WESTON	RT REHABILITATION AN	D NURSING CENTER			CHMOND, VA 23226		
WESTFOR					PROVIDER'S PLAN OF CORR	ECTION	(X5)
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TAG	REGODATORA						<del>                                     </del>
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C 550	Continued From pag	e 25	F	559			'
F 559	Coulinger Lion bas						
	#66/RR (resident rep	resentative) for room , 7/22/21, 8/23/21, and					1
		1122321, 0123/21, 4114					
	8/24/21.						1
	Decident #66 was at	imitted to the facility on					
	12/7/18 with a diagn	osis of dementia with					
	hehaviors On the m	ost recent MDS (minimum					
	data set) a quarterly	assessment with an ARD	60		<u> </u>		ŀ
1	l (assessment referen	ice date) of 8/5/21, Resident	10				]
ļ	#66 was coded as h	aving no cognitive	18		İ		- [
	impairment for making	ng daily decisions, having	12		1		1
1	scored 15 out of 15	on the BIMS.					
	İ						1
	A review of the resid	lent's clinical record revealed					
	they were transferre	d to a new room in the facility					
1	on 6/21/21, 7/22/21,	8/23/21, and 8/24/21. On evidence of written notice of					1
	9/29/21 at 4:30 p.m.	ovided to the resident/RR					1
	(resident representa	ative) and evidence					
	orientation of the re-	sident to the new	1				
.]	room/roommate wa	s requested.					
	1						
İ	On 9/30/21 at 10:57	a.m., OSM (other staff					
1	member) #5, the ad	Imissions coordinator, was					
	Linterviewed, When i	asked if she has a role in					
	internal room transf	ers, she stated the social					
	workers are in char	ge of room transfers. She			1		
	stated the social wo	orkers inform her of residents					
	who need a room o	hange, and will inform her					[
{	once the change is	complete.					
	0 40/4/04 =4 40-2	4 a.m., OSM #4, the director of					
	On 10/4/21 at 10:3	s interviewed. She stated she			Į.		
	social services, wa	king at the facility for three					
	nad only user wor	he could not speak to the					
	residents' room chi	anges before she started to					
	work She stated s	he has a form she uses to					
	to all room transfel	rs. She stated this should be a					1
1		the team, and this team					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING				(X3) DATE SURVEY COMPLETED	
			495227	B. WING	BUILDING		l .	C 10/05/2021	
		VIDER OR SUPPLIER	NURSING CENTER		7300 FOREST AVE	COOE			
PRI	EFIX AG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD B		(X5) COMPLETION DATE	
F	mre re re re re re re re re re re re re r	sident/RR should be ason for the transfer ients the resident to etermines room comparing the resident of the r	cumented. She stated the enotified and told the coordinate of the new room, and patibility. She stated she is everything she does to and to prepare the resident nate.  I.M., LPN (licensed practical nager, was interviewed. She are managed by the social ed, "They try to make sure of properly together."  I.A. ASM (administrative director of nursing, was dell rooms in the facility residents with either private icaid as payer sources. Its/RRs should be notified stated a room change is resident request, an or a roommate issue. ASM of the concerns its for this resident.	F	559				

DELLATOR	MENT OF HEALTHAN	ATTIONED OF DIVICES					0.0000 000.	
CENTER	ENTERS FOR MEDICARE & MEDICAID SERVICES  (X1) PROVIDERSUPPLIERCLIA		(X2) MULT	IPLE CO	(X3) DATI	(X3) DATE SURVEY COMPLETED		
TATEMENT C	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI				С	
AD FEMALO:	O THE STATE OF THE		1			4	)/05/2021 <u> </u>	
		495227	B. WING		TO CODE		10312021	
NAME OF B	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE			
		A CONTROL			0 FOREST AVE			
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F 559		n was provided prior to exit.	F	559				
	notice of the room of	/ failed to evidence written nange provided to Resident epresentative) for room						
	5/21/21, and most rewith diagnoses includisease (dialysis depulmonary disease obesity. On the most set), an admission at (assessment referent #513 was coded as impaired for making scored seven out of interview for mental					u ·		
	on 6/3/21. On 9/29/ written notice of the	dent's clinical record revealed , ed to a new room in the facility 21 at 4:30 p.m., evidence of e room change provided to the ent representative), and n of the resident to the new as requested.						
	member) #5, the ad interviewed. When internal room trans workers are in cha	7 a.m., OSM (other staff dmissions coordinator, was asked if she has a rote in fers, she stated the social arge of room transfers. She orkers inform her of residents change, and will inform her is complete.						

CENTERS FOR MEDICARE & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLA		(X2) MULTIPLE C	ONSTRUCTION	COV	(X3) DATE SURVEY COMPLETED	
EMENT OF DEFICIENCIES PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			С	
	į			1	0/05/2021	
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AE OF PROVIDER OR SUPPLIER		,				
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STPORT REHABILITATION AN	ID NURSING CENTER	RIC	HMOND, VA 23226	DECTION	(X5)	
VELOUS DECICIONS	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD RE	COMPLETION	
F 559 Continued From page On 10/4/21 at 10:34 social services, was had only been work days. She stated she residents' room chawork. She stated she track room transfers decision made by the meeting should be resident/RR should reason for the transfers orients the resident determines room contents the resident determines room contents the resident of the transfers of the transfers or the transfer	a.m., OSM #4, the director of interviewed. She stated she ng at the facility for three e could not speak to the nges before she started to e has a form she uses to so she stated this should be a se team, and this team documented. She stated the be notified and told the fer. OSM #4 stated she to the new room, and compatibility. She stated she is not everything she does to a and to prepare the resident mmate.	F 559				
nurse) #10, a unit r stated room chang workers. LPN #10 we have people pa On 10/4/21 at 3:39	nanager, was interviewed. Site es are managed by the social stated, "They try to make sure ired properly together."  p.m., ASM (administrative the director of nursing, was			?	8.	
interviewed. She sare certified to hou pay, Medicare, or ASM #2 stated resof room changes. usually prompted isolation requirem #2 stated there is the team, and the this time ASM #2	tated all rooms in the facility use residents with either private Medicaid as payer sources. Sidents/RRs should be notified She stated a room change is by a resident request, an ent, or a roommate Issue. ASM usually a conversation among social worker is in charge of of documenting the process. At was informed of the concerns ansfers for this resident.					

DEPARTI	MEINT OF TILABITA	MEDICAID SERVICES					0.0330-0331
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	(X3) DAT	(X3) DATE SURVEY COMPLETED	
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		495227	B. WING			1	0/05/2021
OF BE	ROVIDER OR SUPPLIER			1	ET ADDRESS, CITY, STATE, ZIP CODE		
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WESTPOR	T REHABILITATION AN	D NURSING CENTER		RICH	MOND, VA 23226		<del></del>
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F 559	Continued From pag	formed of these concerns.		1			
	administrator, was in	nt should have had the					
	He stated the resider	he new roommate and see					
	the new room, ASM	#1 stated the reason for the					
	transfer should be do	ocumented in the clinical					
	record, whether it be	patient choice or a clinical					
	need.						
	No further information	n was provided prior to exit.					
	Complaint Deficienc	у					
	notice of the room cl #139/RR (resident ro	failed to evidence written hange provided to Resident epresentative), and failed to of the resident to the new room transfers on 6/3/21, and	1				
	9/14/20 with diagno disorder, dementially disorder. On the mo data set), a quarter! (assessment refere: #139 the resident w	admitted to the facility on ses including schizoaffective with behaviors, and psychotic let recent MDS (minimum y assessment with an ARD nace date) of 9/8/21, Resident less coded as being severely for making daily decisions, but of 15 on the BIMS (brief i status).	e)   <sup>-7</sup>		. 9	Si .	
	they were transferred on 6/3/21, and 7/5/2 evidence of written	dent's clinical record revealed ed to a new room in the facility 21. On 9/29/21 at 4:30 p.m., notice of the room change ident/RR (resident mmate was requested.					
	On 9/30/21 at 10:5	7 a.m., OSM (other staff dmissions coordinator, was					
1	member) #5, tile at	alling digital and a serial se		- Fa	Fility ID: VA0270	f continuation	sheet Page 30 o

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					E SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	CON	MPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILD	ING _			С
						1	0/05/2021
		495227	B, WING		TREET ADDRESS, CITY, STATE, ZIP CODE		0,00,202
NAME OF PE	ROVIDER OR SUPPLIER						
					300 FOREST AVE		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		F	RICHMOND, VA 23226		(X5)
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F 559	Continued From paginterviewed. When a internal room transfer workers are in charg stated the social wor who need a room chonce the change is concerned to concerned the change is concerned to concerned the change is concerned to concerned the change is concerned to change is concerned to change is concerned to change the change is concerned to change the change is concerned to change workers. LPN #10 significant is the resident of the change workers. LPN #10 significant is concerned to change workers.	e 30 sked if she has a role in rs, she stated the social e of room transfers. She kers inform her of residents ange, and will inform her complete.  a.m., OSM #4, the director of interviewed. She stated she right at the facility for three e could not speak to the right at the facility for three e could not speak to the right at the stated to e has a form she uses to a she stated this should be a e team, and this team right at the facility. She stated the be notified and told the right at the room, and mpatibility. She stated she is not everything she does to and to prepare the resident right at the right at the resident right at the ri	F	559			
	pay, Medicare, or M ASM #2 stated resi of room changes. S	Medicaid as payer sources. dents/RRs should be notified the stated a room change is y a resident request, an int, or a roommate issue. ASM					

PRINTED: 10/19/2021 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B, WING			1	C 05/2021	
NAME OF P	ROVIDER OR SUPPLIER		<u>I</u>	Ī	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	03/2021	
WESTPO	RT REHABILITATION AND	NURSING CENTER			7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	#2 stated there is usuathe team, and the soot the process, and of dothis time, ASM #2 was regarding room transfer.  On 10/4/21 at 5:06 p.r administrator, was infoliated the resident opportunity to meet the the new room. ASM # transfer should be doorecord, whether it be proceed.  No further information.  Complaint Deficiency.  12. The facility staff fair notice of the room chather information to the room chather information.  Resident #515/RR (resident reptransfers on 6/2/21.  Resident #515 was ad 4/9/21 with diagnoses fracture and history of recent MDS (minimum assessment with an Afdate) of 4/13/2, Reside being severely cognitive.	ally a conversation among lal worker is in charge of commenting the process. At a informed of the concerns ers for this resident.  In., ASM #1, the formed of these concerns, should have had the enew roommate and see it stated the reason for the tumented in the clinical latient choice or a clinical latient choice or a clinical was provided prior to exit.  Ited to evidence written inge provided to Resident resentative) for room  Initited to the facility on including back bone a stroke. On the most data set), an admission RD (assessment reference int #515 was coded as ely impaired for making scored six out of 15 on the	F	559				
	A review of the residenthey were transferred to on 6/2/21. On 9/29/21	t's clinical record revealed o a new room in the facility at 4:30 p.m., evidence of om change provided to the						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B, WING			1	C	
NAMEOER	ROVIDER OR SUPPLIER	493227	15, 11,110			10/	05/2021	
	RT REHABILITATION ANI	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE	
	room/roommate was a member) #5, the admi interviewed. When asi internal room transfers workers are in charge stated the social work who need a room charge once the change is co.  On 10/4/21 at 10:34 a social services, was in had only been working days. She stated she cresidents' room chang work. She stated she track room transfers. Sidecision made by the meeting should be doer someting should be doer eason for the transfers orients the resident of the transfer orients the resident for a new room/roomm.  On 10/4/21 at 12:45 p. nurse) #10, a unit man stated room changes a workers. LPN #10 state we have people paired.  On 10/4/21 at 3:39 p.m staff member) #2, the cinterviewed. She stated.	of the resident to the new requested.  Im., OSM (other staff assions coordinator, was sted if she has a role in a set of she stated the social of room transfers. She are inform her of residents ange, and will inform her amplete.  Im., OSM #4, the director of atterviewed. She stated she at the facility for three could not speak to the asset of she stated the she was a form she uses to she stated this should be a deam, and this team attempted. She stated the notified and told the cook was a form she uses to she stated the notified and told the cook was a form she used the notified and told the cook was a form she was to she stated the notified and told the cook was a form she was to she	F					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		LE CONSTRUCTION		E SURVEY PLETEO	
		495227	B, WING				C /05/2021	
NAME OF P	ROVIDER OR SUPPLIER			Π	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	10312021	
				1	7300 FOREST AVE			
WESTPO	RT REHABILITATION ANI	NURSING CENTER		i .	RICHMOND, VA 23226			
	SIR/MADV CT/	ATEMENT OF DEFICIENCIES	1 10	Щ				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 559	pay, Medicare, or Med	ficaid as payer sources.	F	559	3			
		nts/RRs should be notified						
		stated a room change is						
	usually prompted by a	• •					1	
		or a roommate issue. ASM						
		ally a conversation among						
		al worker is in charge of cumenting the process. At						
		informed of the concerns						
	regarding room transfe							
	On 10/4/21 at 5:06 p.n	n., ASM #1, the					i	
	administrator, was info	rmed of these concerns.						
	He stated the resident	should have had the					ļ	
1	opportunity to meet the	new roommate and see						
1		stated the reason for the	İ					
	transfer should be doc		1					
	•	atient choice or a clinical 💨						
	need.	88	1		*		154	
	No further information	was provided prior to exit.			8		1	
	Complaint Deficiency							
	13. The facility staff fail							
	notice of the room chair	•					!	
		dent representative) for					[	
	room transfers on 6/2/2	21, 6/30/21, 8/21/21,						
	9/13/21, and 9/15/21.	20	-					
	Resident #13 was adm	•						
	2/27/21 with diagnoses					,		
		disease (lung disease),				!		
		buse. On the most recent et), a quarterly assessment						
	with an ARD (assessm							
	7/1/21, Resident #13 w			1				
		r making daily decisions,						
	having scored 15 out of							

		(X1) PROVIDER/SUPPLIER/CLIA . IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING				C //05/2021
	ROVIDER OR SUPPLIER	NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		103/2021		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	they were transferred on 6/2/21, 6/30/21, 8/2 On 9/29/21 at 4:30 p.n notice of the room charesident/RR (resident requested.  On 9/30/21 at 10:57 a. member) #5, the admisinterviewed. When ask internal room transfers workers are in charge of the control of the co	atus).  atus).  atus).  ati's clinical record revealed to a new room in the facility 21/21, 9/13/21, and 9/15/21.  an., evidence of written nge provided to the representative) was  arm., OSM (other staff esions coordinator, was ted if she has a role in the stated the social of room transfers. She are inform her of residents age, and will inform her	F	559			
	social services, was intended only been working days. She stated she cresidents' room change work. She stated she had track room transfers. Sidecision made by the temeeting should be door resident/RR should be reason for the transfer. Orients the resident to tidetermines room comprequired to document e	ould not speak to the es before she started to as a form she uses to he stated this should be a eam, and this team umented. She stated the notified and told the OSM #4 stated she he new room, and atibility. She stated she is verything she does to d to prepare the resident					
r	nurse) #10, a unit mana	n., LPN (licensed practical ager, was interviewed. She re managed by the social					

A95227   S. WING		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	TION (X3) DATE COMP	
MANE OF PROVIDER OR SUPPLIER  WESTPORT REHABILITATION AND NURSING CENTER  RICHMOND, VA. 23236  PRINTED  GRAND REPERCENCENT WASTE REPRESENCED BY PALL REGULATORY OR LSC IDENTIFYING MYORMATION)  F 559  Continued From page 35  workers, LPN #10 stated, "They try to make sure we have people paired properly together."  On 104/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources.  ASM #2 stated residents/RRs should be notified of room change is usually prompted by a resident request, an isolation requirement, or a comment issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.  On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of the concerns regarding room transfers for this resident.  On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of the concerns regarding room transfers for this resident.  No further information was provided prior to exit.  Complaint Deficiency  14. The facility staff falled to evidence written notice of the room change provided to Resident #516/RR (resident representative) for room transfers on 6/1/21.  Resident #516 was admitted to the facility on			407007					
WESTPORT REHABILITATION AND NURSING CENTER  TO SUBMANAY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SEP PRECEDED BY FILL TAG SULVITORY OR LSC IDENTIFYING INFORMATION)  F 559  Continued From page 35  workers. LPN #10 stated, "They try to make sure we have people paired properly together."  On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medical as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.  On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.  No further information was provided prior to exit.  Complaint Deficiency  14. The facility staff falled to evidence written notice of the room change provided to Resident #516/RR (resident representative) for room transfers on 6/1/21.  Resident #516 was admitted to the facility on			495227	B, WING			10/	05/2021
PREFEX TAG			D NURSING CENTER		73	300 FOREST AVE		
workers. LPN #10 stated, "They try to make sure we have people paired properly together."  On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.  On 10/4/21-at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.  No further information was provided prior to exit.  Complaint Deficiency  14. The facility staff failed to evidence written notice of the room change provided to Resident #516/RR (resident representative) for room transfers on 6/1/21.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION			
with diagnoses including history of stroke with		workers, LPN #10 stat we have people paired On 10/4/21 at 3:39 p.r. staff member) #2, the interviewed. She state are certified to house it pay, Medicare, or Medicare, was info He stated the resident opportunity to meet the new room. ASM #3 transfer should be door record, whether it be princed.  No further information of Medicare, or Medicare	led, "They try to make sure d properly together."  In., ASM (administrative director of nursing, was d all rooms in the facility residents with either private licaid as payer sources. Ints/RRs should be notified stated a room change is resident request, an or a roommate issue. ASM ally a conversation among al worker is in charge of cumenting the process. At informed of the concerns are for this resident.  In., ASM #1, the remed of these concerns should have had the enew roommate and see I stated the reason for the umented in the clinical atient choice or a clinical was provided prior to exit.  In. ASM #1, the resident enemed in the clinical atient choice or a clinical was provided to Resident esentative) for room	r.	559			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING			C 10/05/2021	
	ROVIDER OR SUPPLIER	) NURSING CENTER	•	73	REET ADDRESS, CITY, STATE, ZIP CODE 100 FOREST AVE ICHMOND, VA 23226		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	with an ARD (assessm 5/8/21, Resident #516 cognitive impairment if having scored 13 out of interview for mental state of they were transferred to 6/1/21. On 9/29/21 written notice of the roresident/RR (resident revidence orientation of room/roommate was recommended by the admissinterviewed. When ask interviewed. When ask interviewed a room channonce the change is conducted the social worker who need a room channonce the change is conducted. On 10/4/21 at 10:34 ausocial services, was interviewed. When ask stated the social worker who need a room channonce the change is conducted. She stated she coresidents' room change work. She stated she have the commended to the transfer. Sidecision made by the tempeting should be documented to the transfer.	most recent MDS n admission assessment nent reference date) of was coded as having no or making daily decisions, of 15 on the BIMS (brief atus).  It's clinical record revealed to a new room in the facility at 4:30 p.m., evidence of orn change provided to the representative), and if the resident to the new equested.  In., OSM (other staff asions coordinator, was ed if she has a role in of room transfers. She are inform her of residents age, and will inform her niplete.  In., OSM #4, the director of erviewed. She stated she at the facility for three ould not speak to the as a form she uses to the stated this should be a team, and this team umented. She stated the notified and told the OSM #4 stated she	F	559			

STATEMENT	T OF DEFICIENCIES	(X1) BBOUDERFRIEND WEEK			OMB N	IO. 0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDI	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		495227	B. WING		1	С
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		0/05/2021
WESTPO	RT REHABILITATION AND	NURSING CENTER		7300 FOREST AVE RICHMOND, VA 23226	-	
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR	SHOULD BE	(X5) COMPLETION DATE
the state of the s	required to document of notify a resident/RR and for a new room/roomm.  On 10/4/21 at 12:45 p.inurse) #10, a unit manastated room changes at workers. LPN #10 state we have people paired.  On 10/4/21 at 3:39 p.m. staff member) #2, the did interviewed. She stated are certified to house repay, Medicare, or Medicare, or Medicare, or Medicare, or Medicare stated there is usually prompted by a resolution requirement, or #2 stated there is usually he team, and the social he process, and of documents time, ASM #2 was integarding room transfers.  On 10/4/21 at 5:06 p.m., dministrator, was informate stated the resident she portunity to meet the new transfers.	everything she does to ad to prepare the resident ate.  m., LPN (licensed practical ager, was interviewed. She are managed by the social d, "They try to make sure properly together."  ASM (administrative prector of nursing, was all rooms in the facility sidents with either private aid as payer sources. SARS should be notified tated a room change is assident request, an a roommate issue. ASM or a conversation among worker is in charge of menting the process. At formed of the concerns for this resident.  ASM #1, the led of these concerns, ould have had the ew roommate and see ated the reason for the ented in the clinical ent choice or a clinical ent choice or a clinical ent choice or a clinical ent choice.	F5			
15	. The facility staff failed	to evidence written				1

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B, WING			C	
1	PROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226		0/05/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(XS) COMPLETION DATE	
	notice of the room children with the administrative of the resident representative) was resident with the administrative of the administrative of the resident with the administrative of the resident with the administrative of the resident with the administrative of the resident representative) was resident with the administrative of the resident representative) was resident on 6/3/21 at 10:57 at member) #5, the administrative wed. When ask internal room transfers workers are in charge work who need a room change is coronce the change is coronce the change is coronce the change is coronce the change is coronce work. She stated she coresidents' room change work. She stated she track room transfers. Sidecision made by the terministrative of the stated she to the coron change work. She stated she track room transfers. Sidecision made by the terministrative of the stated she to the stated she that	ange provided to Resident presentative) for room and 7/22/21.  Idmitted to the facility on sis of Alzheimer's disease.  DS (minimum data set), an aith an ARD of 8/10/21, and as being severely or making daily decisions, and 15 on the BIMS (brief latus).  Int's clinical record revealed to a new room in the facility.  On 9/29/21 at 4:30 p.m., alice of the room change and the room change and the social of room transfers. She are sinform her of residents are, and will inform her anplete.  Int., OSM #4, the director of the room transfers. She are inform her of residents are and will inform her anplete.  Int., OSM #4, the director of the stated the sated the sated the sated the sated the sated the sated the sated the sated the sated the sated the sated the sated the sated the sated the sated this should be a sam, and this team urmented. She stated the	F	559			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	MENT OF HEALTH AN					FO	TED: 10/19/2021 RM APPROVED NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495227	B. WING				10/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	·		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
WESTPO	RT REHABILITATION AND	NURSING CENTER			7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XS) COMPLETION DATE	
	reason for the transfer orients the resident to determines room commequired to document notify a resident/RR at for a new room/roomn  On 10/4/21 at 12:45 p. nurse) #10, a unit man stated room changes aworkers. LPN #10 stat we have people paired on 10/4/21 at 3:39 p.n. staff member) #2, the interviewed. She state are certified to house of pay, Medicare, or Med ASM #2 stated resider of room changes. She usually prompted by a isolation requirement, #2 stated there is usual the team, and the sociation requirement, was regarding room transfer. On 10/4/21 at 5:06 p.m administrator, was info He stated the resident opportunity to meet the the new room. ASM #1 transfer should be doce	the new room, and patibility. She stated she is everything she does to and to prepare the resident nate.  Im., LPN (licensed practical nager, was interviewed. She are managed by the social ed, "They try to make sure I properly together."  In., ASM (administrative director of nursing, was d all rooms in the facility esidents with either private icaid as payer sources. Its/RRs should be notified stated a room change is resident request, an or a roommate issue. ASM of the concerns are for this resident.  In., ASM #1, the med of these concerns are for this resident.	F	559				
	No further information v	was provided prior to exit.			ii			

		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
			405003		B. WING		C	
ŀ			495227	B. WING			10/	05/2021
		ROVIDER OR SUPPLIER RT REHABILITATION AND	NURSING CENTER		7300 F	T ADDRESS, CITY, STATE, 2JP CODE DREST AVE NOND, VA 23226		
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
		Complaint Deficiency  16. The facility staff fa notice of the room cha #511/RR (resident rep transfers on 6/4/21.  Resident #511 was ad 5/28/21 with diagnose replacement and high discharged from the fa most recent MDS (mir admission assessmen reference date) of 6/3/ coded as having no in decisions, having scor BIMS (brief interview f A review of the resident they were transferred on 6/4/21. On 9/29/21 written notice of the ro resident/RR (resident evidence orientation o room/roommate was ro  On 9/30/21 at 10:57 a. member) #5, the admi- interviewed. When ask internal room transfers workers are in charge	illed to evidence written ange provided to Resident presentative) for room  Imitted to the facility on a including a left total knee blood pressure. He was excility on 8/9/21. On the inimum data set), an at with an ARD (assessment 121, Resident #511 was apairment for making daily red a 15 out of 15 on the for mental status).  In this clinical record revealed to a new room in the facility at 4:30 p.m., evidence of om change provided to the representative), and if the resident to the new equested.  Im., OSM (other staff ssions coordinator, was sed if she has a role in 5, she stated the social	F	559	DEPOLENCY		
			mplete. m., OSM #4, the director of terviewed. She stated she pat the facility for three					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405497	D MAINIG	B, WING		С	
		495227	B, WING		10/	/05/2021	
	ROVIDER OR SUPPLIER	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 559	work. She stated she track room transfers. She clearly the meeting should be do resident/RR should be reason for the transfer orients the resident to determines room commequired to document notify a resident/RR at for a new room/roomm On 10/4/21 at 12:45 p. nurse) #10, a unit mar stated room changes at	les before she started to has a form she uses to she stated this should be a team, and this team cumented. She stated the motified and told the cost of the new room, and patibility. She stated she is everything she does to not to prepare the resident nate.  In LPN (licensed practical larger, was interviewed. She are managed by the social ed, "They try to make sure	F	559			
	staff member) #2, the interviewed. She state are certified to house r pay, Medicare, or Med ASM #2 stated resider of room changes. She usually prompted by a isolation requirement, we will be the process, and of do this time, ASM #2 was regarding room transferom transferom to the stated the resident opportunity to meet the	or a roommate issue. ASM ally a conversation among al worker is in charge of cumenting the process. At informed of the concerns ars for this resident.  a., ASM #1, the rmed of these concerns.	5			·	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/19/2021 FORM APPROVED OMB NO. 0938-0391

CENTER	42 FOR MEDICARE &	MEDICAID SEKAICES					CIND NO	7. 0300-0001	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING				(X3) DATE SURVEY COMPLETED		
		495227	B WING	8, WING			C 10/05/2021		
NAME OF P	PROVIDER OR SUPPLIER	495227	D.WING_	STREET A	DORESS, CITY, STATE, ZIP CO	DDE	1 10/	05/2021	
	RT REHABILITATION AN	D NURSING CENTER		7300 FOR					
	CIMANADVET	ATEMENT OF DEFICIENCIES	TID	KIOTINIO	PROVIDER'S PLAN OF C	ORRECTION		(XS)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG		(EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD E 1E APPROPRI	BE	COMPLETION DATE	
F 559	Continued From page	42	F 5	59					
	1	cumented in the clinical patient choice or a clinical							
	No further information	was provided prior to exit.							
	Complaint Deficiency								
	Resident #514 was at 4/16/21 with diagnose (body-wide infection), infection), morbid obe	osteomyelitis (bone							
	(paralysis of legs). On	the most recent MDS						3	
. 1	11.	quarterly assessment with reference date) of 7/22/21,			-53 26				
		ided as being cognitively			£ 8		100		
	intact for making daily 13 out of 15.	decisions, having scored		3.2					
	they were transferred on 6/5/21, 7/6/21, and 4:30 p.m., evidence of change provided to the representative), and e	nt's clinical record revealed to a new room in the facility 7/23/21. On 9/29/21 at f written notice of the room e resident/RR (resident vidence orientation of the						VDI	NOV S
	resident to the new roorequested.	om/roommate was						0/1	92
	interviewed. When asl internal room transfers	ssions coordinator, was ked if she has a role in						LC	121

stated the social workers inform her of residents

- unors				OMB NO. O	938-0391 18VEY
NT OF HEALTH AND HUMAN SERVICES			- INCOM	COMPLE	TEO
NT OF HEALTH AND HUMAN SERVICES OR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (X2) PROVIDER/SUPPLIER/CLIA (X3) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CON	ISTRUCTION	1	
	A, BUILDIN	IG		C	
DENTIFICATION	Д. 0-11			10/0	5/2021
DRRECTION	B. WING _				
495227	B. 11,144	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		1
444		7700	FOREST AVE		1
		1300			(X5)
OWIDER OR SUPPLIER		RIC	PROVIDER'S PLAN OF CORRECTION	N	COMPLETION
TATION AND NURSING CERTER	10	1	PROVIDER'S PLAN OF CORRECTION SHOULD  (EACH CORRECTIVE ACTION SHOULD  TO THE APPROPRIED TO THE APPROPR	RIATE	DATE
SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES	PRE		CROSS-REFERENCED TO THE APPROP		
SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)	TA	G ∖	DEFICIENCY		
FACH DEFICIENCY MUST BE INFORMATION					
SUMMARY STATEMENT SEPRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY OF LSC IDENTIFYING INFORMATION)	1	1			1
	1	F 559			
	1				
Continued From page 43	1		1		
Continued From page 43 who need a room change, and will inform her who need a room change is complete.	1		1		
who need a room change is complete. once the change is complete.	1				
On 10/4/21 at 10:34 a.m., OSM #4, the director of On 10/4/21 at 10:34 a.m., OSM #6, the stated she	1		1		
. 40:34 a.m., OSM #4, the director	- 1		l l		1
On 10/4/21 at 10:34 stated sho	1				1
had only been working at the facility for the had only been working at the had only been worki	}				
had only been when the could not speak to days. She stated she could not speak to days. She stated to residents' room changes before she started to residents' room changes a form she uses to					1
residents' room changes before site states residents' room changes before site states to work. She stated she has a form she uses to work. She stated this should be a	1				1
	1				
residents' foom one has a form she uses to work. She stated she has a form she uses to work. She stated this should be a track room transfers. She stated this should be documented. She stated the decision made by the team, and this team decision made by the team, and this stated the	1				
	1				1
meeting should be documented. She be meeting should be notified and told the resident/RR should be notified and told the resident/RR should be roughly a the transfer. OSM #4 stated she	1		1		
	\		\		
reason for the transfer. OSM #4 stated reason for the transfer. OSM #4 stated reason for the transfer. OSM #4 stated reason for the transfer. OSM #4 stated reason for the	1				1
	1		\		
reason for the trade of the new room, and orients the resident to the new room, and orients the resident to the new room. She stated she is determines room compatibility. She stated she is determines room compatibility. She stated she is determined to document everything she does to require the resident regident of the resident of the room	1		1		
determines room compared to document everything she does to required to document everything she does to required to document everything she does to require to do do do do do do do do do do do do do	1				. *8
required to doest/RR and to prepare the	}			4	1
notify a residential to notify a residential for a new room/roommate.	l				
for a new rooms	ál	1			
12:45 p.m., LPN (licensed prod. S	he	1			1
On 10/4/21 at 12th manager, was interviewed	al	1			9
On 10/4/21 at 12:45 p.m., LPN (licensed pressured) and the social stated from changes are managed by the social stated from changes are managed by the social stated from the social workers. LPN #10 stated, "They try to make sured properly together."	re	1			
	•	1	1		
workers. LPN #10 stated, "They try to workers. LPN #10 stated, "They try to workers." we have people paired properly together."		1	1		
		1			1
ASM (administrative		1	1		
On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was staff member of the stated all rooms in the facility is the stated all rooms in the stated all rooms in the stated all rooms.		1			
staff member) #2, the dill rooms in the facility	y				
on 10/4/21 at one of nursing, staff member) #2, the director of nursing, staff member) #2, the director of nursing, staff member) #2, the director of nursing in the facility interviewed. She stated all rooms in the facility are certified to house residents with either printing of Medicaid as payer sources.	ASIC	1	1		
are certified to house residuant as paver sources		1	S++		1
interviewed. Some residents with entropy are certified to house residents with entropy are certified to house residents as payer sources pay, Medicare, or Medicaid as payer sources pay, Medicare, or Medicaid as payers and ASM #2 stated a room change.	tied		S200		
	is	1	1		
About changes. She stated a formest, an		1			1
of room changes. She stated a room of room changes. She stated a room usually prompted by a resident request, an usually prompted by a roommate issue. isolation requirement, or a roommate issue.	ASM	1			
usually promittement, or a roomittate to	nong		\		
isolation requirement, or a roommate issued isolation requirement, or a roommate issued isolation and the social worker is in charge and the social worker is in charge.	e of	1			
#2 stated the social worker is in croce	ss. At				nation sheet Page 44 of 254
#2 stated there is usually a conversation with the team, and the social worker is in charge the team, and of documenting the process, and of documenting the control of the	cems	1	1/40070	If continu	William Princer 1 200 de la constante
the team, and the social worker is in criary the team, and the social worker is in criary the process, and of documenting the process, and of documenting the process, and as was informed of the contribution. ASM #2 was informed of the contribution.	Event ID:	IEVI.11	Facility ID: VA0270		
this time. ASW #2	Event in:				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495227	B. WING		C 10/05/2021
	ROVIDER OR SUPPLIER	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
F 559	Continued From page regarding room transfer On 10/4/21 at 5:06 p.r.	ers for this resident.	F 55	9	
	administrator, was info He stated the resident opportunity to meet the the new room. ASM # transfer should be doo record, whether it be p need.	ormed of these concerns. should have had the e new roommate and see I stated the reason for the umented in the clinical atient choice or a clinical was provided prior to exit. led to provide written #383 and or the			
	diagnoses that includer fracture of left femur (1 disorder (2). Resident (minimum data set), a can ARD (assessment recoded Resident #383 a interview for mental state being cognitively intact. The admission record focumented Resident #2 responsible party, powermergency contact.  The census list for Resident #3 resident #3 resident #3 responsible party, powermergency contact.	for making daily decisions. or Resident #383 #383's son as their			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
<u> </u>		495227	B. WING			С	
NAME OF P	PROVIDER OR SUPPLIER	433227		REET ADDRESS, CITY, STATE, ZIP C	ODE	10/05/2021	
WESTPO	RT REHABILITATION AND	NURSING CENTER		00 FOREST AVE CHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 559	Continued From page	45	F 559				
	for acquisition of CRE enterobacteriaceae) (3 exposure. Date Initiati on: 06/14/2021."	e of Resident #383] at risk (carbapenem-resistant I) related to possible ed: 06/01/2021; Revision					
	Resident continues on (urinary tract infection) afebrile, n.o. (new order (responsible party) awardose rm (room) door. I redirected, Resident to distress noted."  " "5/28/2021 17:20 (Writer spoke with RP a	e following: (4:09 p.m.) Note Text: abt (antibiotic) for uti . Resident remains er) rectal swab. RP are. Resident refuses to Resident not easily ilets self in room. No 5:20 p.m.) Note Text: nd Resident, who confirms					
	Writer requested to conspeak with Resident. Win regards of concerns precaution status. Write the meaning of contact was currently on contact answered to Resident's also stated that "I want going on with me." Write results of rectal swa (medical doctor) /nursedid inform Resident that holiday weekend and the obtaining the results, reunderstanding."	11:51 a.m.) Note Text:  ne to Resident's room to  friter spoke with resident of current contact er educated Resident on precautions and why she et precautions. Questions satisfactory. Resident to know everything that is er assured Resident once b were obtained MD would notify her. Writer t unfortunately, it was a ere may be a delay in sident verbalized  a.m.) Note Text: al with some confusion.			EQ. (Pr		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A, BUILDING		(X3) DATE SURVEY COMPLETED
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		495227	B. WING		10/05/2021
	PROVIDER OR SUPPLIER RT REHABILITATION AND	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE COMPLETION
	to close room door. Re out of room writer edu voiced no further conc "6/1/2021 10:41 (10:4' continues on contact p not in at this time. Res discomfort at this time. Son r/t (related to) time living) care. Writer noti per resident it happens will notify UM (unit man At this time resident to assisted as needed by "6/1/2021 11:23 (11:23 reported on 5/27/2021 entered another room is contact precautions. Fathealth department] for recommendation reside and did not warrant need further evaluation, reside and did not warrant need further evaluation, reside and did not warrant need further evaluation, reside and further evaluation, reside and further evaluation, reside and further evaluation, reside and further evaluation, reside and further evaluation, reside and further evaluation, reside and further evaluation, reside and further evaluation, reside and further evaluation, reside and further evaluation, reside and further evaluation reside and further evaluation reside and further evaluation residence further evaluation residence further evaluation residence further evaluation residence further evaluation residence further evaluation residence further evaluation, residence further evaluation residence further evaluation residence further evaluation residence further evaluation residence further evaluation reside	re results. Resident refuses esident requests to come cated resident. Resident erns."  I a.m.) Note Text: Resident creautions. Rectal culture ident denies pain or writer received call from ein adl (activities of daily fied son it was not day shift ed on another shift. Writer mager) with further details. Iderated therapy and staff."  a.m.) Note Text: Staff resident had during night in which resident was in acility reported to [Name of further guidance. Initial ent exposure was minimal ed for surveillance. 'Upon dent utilizing shared conduct surveillance wab. Resident son/RP P (nurse practitioner) lame of local health rare, results pending."  Resident #383 failed to on of notification of the ding the room change on a.m., ASM (administrative irector of nursing stated amed in the complaint no cility.	F	559	

A. BUILDING	(X3) DATE SURVEY COMPLETED	
	С	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	0/05/2021	
WESTPORT REHABILITATION AND NURSING CENTER  7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 559 Continued From page 47 conducted with LPN (licensed practical nurse) #8. LPN #8 stated that they did not recall any conversations with Resident #383's responsible party notifying them of the room change.  On 10/4/2021 at 12:54 p.m., an interview was conducted with OSM (other staff member) #5, the admissions coordinator. OSM #5 stated that they had multiple conversations with Resident #383's responsible party regarding requests to have a private room. OSM #5 stated that when a resident required a room change for isolation purposes the nurses would contact the social worker to contact the responsible party. OSM #5 stated that there were currently no social workers in the facility who worked there in May and June of 2021.  On 10/4/2021 at 2:50 p.m., an interview was conducted with LPN #12. LPN #12 stated that they worked the night shift (11:00 p.m7:00 a.m.) when Resident #383 was moved to another room. LPN #12 stated that a CNA (certified nursing assistant) had reported to them that Resident #383 had entered into a residents room who was on isolation for CRE by mistake and possibly been exposed by using a shared bathroom so they had moved Resident #383's na shorter room and placed them on isolation. LPN #12 stated that they did not recall any conversations with Resident #383's responsible party regarding the room change.  On 10/4/2021 at 5:15 p.m., an interview was conducted with RN (registered nurse) #3, the infection preventionist. RN #3 stated that Resident #384 wandered into a niton on there		

	TO TOTA MEDIOPINE OF	MEDIONIO OFILAIOEO				CIVID IV	<u>U. 0930-039</u>	<u> 1                                   </u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING			1	C )/05/2021	
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			IAG		DEFICIENCY)	116		
F 559	0	40	3			*		
F 559	- commode i i dini pago		FS	559				
		as on isolation for CRE.	1					i
		had consulted with the		- 1				
100	local health departmen	nt who recommended	1	- 1				
	Resident #383 be place							
		I swab be completed. RN	1				1	
- 0		ervices notified responsible						
		es. RN #3 stated that if	1	- 1				
		during the night the social	1					
		onsible party in the morning						
- 9	to notify them of the ro		1					
	documented in the pro	gress note.						
1	On 10/5/2021 at 12:30	p.m., an Interview was						
		4, the director of social						
	services. OSM #4 stat	ed that when a resident	1					
1		ther room in the facility a						
- 1	transfer form was com						i	
1	responsible party. OS							
	physician was notified	and the resident and	1					ľ
1	responsible party were	notified of the transfer.		40			42	
	OSM #4-stated that the	resident was oriented to	15		5 5 %		7.0	ı
		roommate if applicable					1	1
1	prior to the move. OS!	#4 stated that if the		- 1				١
	move were for infection	control purposes the						
		kly but the process was						ŀ
į.	the same, OSM #4 sta	ted that they had only						١
		few days and were only		- 1				1
100		rocess and not what the					i	1
	previous social worker	followed,						١
	On 10/5/2021 at 8:23 a	.m., an interview was						
4.0	conducted with ASM (a		2				-	1
4.0	member) #2, the directo							ŀ
		nsure when Resident #383						ŀ
13	was moved to another i	room. ASM #2 stated that						
		linical record and see if				1		
- 11	they were able to evide	nce documentation of						
	-	nsible party of the room						
	change on 5/27/2021.							

PRINTED: 10/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCT	(X3) DATE SURVEY COMPLETED			
		495227	B. WING					С
NAME OF P	ROVIDER OR SUPPLIER	493221	1 2. 11110 -	STREET ADDRE	ESS, CITY, STATE, ZIP COD		10	/05/2021
WESTPO	RT REHABILITATION AND	NURSING CENTER		7300 FOREST	AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E/	PROVIDER'S PLAN OF CO ACH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY)	I SHOULD B		(X5) COMPLETION DATE
F 559	Continued From page	49	F 5	59				
	of nursing stated that any evidence of notific party for the room chance of notific party for the room chance of notific party for the room chance of the facility policy, "Room transfers and no party.  The facility policy, "Room transfers and no party.  The facility policy, "Room transfers and no party.  The facility policy, "Room transfers and well-being of resident will be provided of the room change. So reason(s) why the mover ecommendedDocume change is recorded in the record"  The facility policy, "Chance of the facility policy, "Chance of the room chance is recorded in the record"  The facility policy, "Chance of the	eximately 9:15 a.m., a ASM (administrative staff cility policy on inter-facility lification of the responsible com Change/Roommate by 2017 documented in ally necessary or for the control of the resident(s), a control of the resident(s), a control of the resident include the control of a room the resident's medical control of a room the resident's medical control of a room the resident's medical control of a room the resident's medical control of a room the resident's medical control of a room the resident's medical control of a room the resident's medical control of a room the resident's medical control of a room the resident's medical control of a room the resident's medical control of the room the resident's the resident's the resident's control of the residen			277 253 (624			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		C 10/05/2021	
	PROVIDER OR SUPPLIER	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
	in leg. It is also called information was obtain https://medlineplus.gov 00166.htm.  2. Major depressive di disorder. It occurs whe loss, anger, or frustrati life over a long period how your body works. obtained from the webshttps://medlineplus.gov 3. CRE stands for cart Enterobacterales. Ente of germs, specifically b types of Enterobacteral from the webshttps://medlineplus.gov 3. CRE stands for cart Enterobacterales. Ente of germs, specifically b types of Enterobacteral Kescherichia coli (E. coli cause infections includi bloodstream infections, and r major concern for patie because they are resist antibiotics, which are codefense to treat multidrinfections. Often, high le resistance in CRE leave that are more toxic and information was obtained and the standard of the sta	acture (break) in the femurine thigh bone. This ed from the website: //ency/patientinstructions/0 sorder: is a mood in feelings of sadness, on get in the way of your of time. It also changes This information was site: //ency/article/000945.htm.  Appenem-resistant robacterales are an order acteria. Many different es can develop ebsiella pneumoniae and by These bacteria can ing pneumonia, urinary tract infections, ineningitis. CRE are a into in healthcare settings and to carbapenem insidered the last line of ug-resistant bacterial evels of antibiotic e only treatment options less effective. This in the website: /organisms/cre/cre-patient	F 580			
SS=D	CFR(s): 483.10(g)(14)(i	-(iv)(15)	P 560	Resident #383 no longer resides in tri facility.	16	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		495227	B. WING			1	05/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE 10 FOREST AVE CHMOND, VA 23226		
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F 580	§483.10(g)(14) Notifice (i) A facility must immonsult with the residence consistent with his or representative(s) when the consistent with his or representative(s) when the consistent with his or representative(s) when the consistent in the consistent c	cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring et; ge in the resident's physical, ital status (that is, a en, mental, or psychosocial reatening conditions or eatening that is, ean existing form of erea consequences, or to m of treatment); or ser or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the easo promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or eas specified in paragraph erecord and periodically mailing and email) and	F	580	2. All current residents residing in creviewed to ensure notification of responsible representative for all incand changes of condition from since 09/01/2021.  3. DON or designee will educate all nursing staff on centers policy for notification of Responsible represer post incidents and changes of condition and into ascertain notification of RR follow event weekly times 4 weeks and matimes 2 to ensure facility maintains notification. Any identified issues with immediately corrected. Results will reported to Quality Assurance comfor analysis and revision x 3 months.  5. Date of compliance will be	facility stative ition. of cidents ing onthly proper li be be mittee	11/19/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A, BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		495227	B. WING	<del></del>		10/05/2021	
	ROVIDER OR SUPPLIER	D NURSING CENTER	7	STREET AODRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIAT	COMPLETION DATE	
F 580	§483.10(g)(15) Admission to a composite di §483.5) must disclose its physical configural locations that compris part, and must specifi room changes betweender §483.15(c)(9). This REQUIREMENT by: Based on clinical recand facility document a complaint investigathe facility staff failed party of an fall and plesting for one of 84 is sample, Resident #383 The facility staff failed #383's responsible party of an fall on 6/2/21 an x-ray of the resided. The findings include:  Resident #383 was a diagnoses that include fracture of left femuridisorder (2). Resident (minimum data set), an ARD (assessment coded Resident #383 interview for mental seling cognitively intal	osite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations  is not met as evidenced for review, staff interview areview and in the course of tion it was determined that to notify the responsible hysician orders for diagnostic residents in the survey 33.  If to evidence Resident and the physician order for early was notified on Resident and the physician order for ent's left knee.  Idmitted to the facility with led but were not limited to (1) and major depressive at #383's most recent MDS a discharge assessment with the reference date) of 6/5/2021, as scoring a 15 on the brief status (BIMS) scale, 15-ct for making daily decisions, and Resident #383 having one be admission.	F 580				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495227	B. WING			10/	05/2021
	ROVIDER OR SUPPLIER RT REHABILITATION ANI	D NURSING CENTER	*	73	REET ADDRESS, CITY, STATE, ZIP CODE 00 FOREST AVE CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	dated 5/28/2021 docu falls due to history of Initiated: 05/28/2021, Under "Interventions/ part, "Gripper socks of bed as tolerated. Dat "Encourage to transfe slowly. Date Initiated: The physician orders documented in part, " one time only for trace	t #383's son as their wer of attorney and are plan for Resident #383 mented in part, "At risk for falls, left hip fracture. Date Revision on: 06/14/2021." Tasks" it documented in at all times when out of the Initiated: 06/03/2021" and or and change positions 06/03/2021."	F	580			
•	Note Text: CC (chief of earlier this morning" Incess): Resident reposition and as she was leaving her left knee gave was herself to the floor. She was adamant she not have footwear on having gripper socks ambutating. Her left knot much more than p ground level fall in her hip fracture which underessing is intact and	6/2/2021 12:49 (12:49 p.m.) complaint): "I slid to the floor dPI (history of present orts she was in the (4:00 a.m.) with a walker ag the bathroom, she said by nd [sic] she scooted as stated she did not fall. ad did not fall. She also did She was educated on on or shoes when anee is slightly swollen, but be reviously. She had had a ar garage, resulting in a left alterwent repair on 5/23. Her is due to come off within amoval today. I will order					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING				(X3) DATE SURVEY COMPLETED	
		495227	B. WING				C 10/05/2021	
	PROVIDER OR SUPPLIER	NURSING CENTER		730	REET ADDRESS, CITY, STATE, ZIP COD 10 FOREST AVE CHMOND, VA 23226	Æ	1 10.	103/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST 8E PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BI		(X5) COMPLETION DATE
F 580	Continued From page The clinical record fail	54 ed to evidence any post fall	F:	580				
		reported slip to the floor on						
	documentation the res of the reported slip to t	ponsible party was notified the floor on 6/2/2021 or the ax-ray of the resident's left						
		censed practical nurse) #8. y had updated Resident		;			į	
	they worked the night s with Resident #383. Lt remembered speaking responsible party regar being moved and put o	2. LPN #12 stated that hift (11:00 p.m7:00 a.m.) PN #12 stated that they to Resident #383's				2	<i>1</i> 34	
	and see if they were ab	dministrative staff or of nursing. ASM #2 eview the clinical record le to evidence eatlon of the responsible			ty.			
1	#3 stated that they did r	, nurse practitioner. ASM						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	CENTERS FOR MEDICARE & MEDICAID SERVICES  TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE	OMB N	FORM APPRO OMB NO. 0938-0 (X3) DATE SURVEY		
		I SANON NOMBER;	A. BUILDING		COMPLETED		
NAME OF	77.0	495227	B. WING			С	
NAME OF 1	PROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CODE	1(	0/05/2021	
WESTPO	RT REHABILITATION A	ND NURSING CENTER		ID FOREST AVE			
				CHMOND, VA 23226			
(X4) ID PREFIX TAG	I (EVCU DELICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI	NII D DE	(XS) COMPLE DATE	
TO in reference structure of the reference of the referen	reported the slip to the ASM #3 stated that the any conversations will responsible party.  On 10/5/2021 at 12:1 of nursing stated that any evidence of notificity party for the reported and physician ordered and physician ordered and physician ordered and physician ordered and physician ordered and physician ordered and physician ordered and physician ordered and physician ordered and physician ordered and physician ordered and physician ordered and physician ordered and part, "Our facility shaped and part, "Our facility shaped and part, "Our facility shaped and part," our facility shaped and part, "Our facility shaped and part, "Our facility shaped and part," our facility shaped and part, "Our facility shaped and part," or the facility of the property of the physician or the facility of	ne floor on 6/2/2021 to them. They did not remember having the Resident #383's  9 p.m., ASM #2, the director they were unable to locate cation of the responsible slip to the floor on 6/2/2021 it x-ray.  Desimately 9:15 a.m., a a a a a a a a a a a a a a a a a a a	F 580	DEFICIENCY			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495227	B, WING		С
NAME OF F	PROVIDER OR SUPPLIER	433221	0. 771110		10/05/2021
ł	RT REHABILITATION AND	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE COMPLETION
F 580	Continued From page	56	F	580	
F 582 \$S=D	It occurs when feelings or frustration get in the long period of time. It a body works. This infor the website: https://medlineplus.gov Medicaid/Medicare Co		F	1. Resident #483 no longer resides	
	§483.10(g)(17) The fact (i) Inform each Medica writing, at the time of a facility and when the re Medicaid of- (A) The items and serv nursing facility services for which the resident r (B) Those other items a facility offers and for which	cility must id-eligible resident, in dmission to the nursing esident becomes eligible for ices that are included in sunder the State plan and may not be charged; and services that the nich the resident may be	• :	center. Resident #132. 13 remain in center, due to nature of noncomplia unable to complete past events.  2. All residents whose services confrom 10/05/2021 to present receive notification of ending of skilled servithrough Medicare accordingly.  3. DON or designee will educate all service staff on required policy for notification of Responsible represer of termination of skilled services.  4. DON or designee will audit 10% residents with ending of skilled services ascertain receipt of advanced bene	nce apleted d ces social atative of
	changes are made to the specified in §483.10(g) section.  §483.10(g)(18) The factoresident before, or at the periodically during their available in the facility asservices, including any covered under Medicanfacility's per diem rate.  (i) Where changes in contracts	id-eligible resident when he items and services (17)(i)(A) and (B) of this  illity must inform each e time of admission, and resident's stay, of services and of charges for those charges for services not e/ Medicaid or by the  overage are made to items by Medicare and/or by the		and monthly times 2 to ensure facilimate maintains proper notification. Any identified issues will be immediately corrected. Results will be reported Quality Assurance committee for an and revision x 3 months.  5. Date of compliance will be	neks Ny no 11/19/21

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	8. WING			C 10/05/2021	
	ROVIDER OR SUPPLIER	NURSING CENTER	•	7	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
	reasonably possible.  (ii) Where changes are items and services that facility must inform the 60 days prior to impler (iii) If a resident dies or transferred and does or facility must refund to the representative, or estand deposit or charges alreper diem rate, for the coresided or reserved or facility, regardless of a discharge notice require (iv) The facility must representative the resident representative the resident within 30 or date of discharge from (v) The terms of an addischarge for an individual shealf of an individual	the change as soon as is a made to charges for other at the facility offers, the president in writing at least mentation of the change. It is hospitalized or is not return to the facility, the the resident, resident te, as applicable, any eady paid, less the facility's lays the resident actually retained a bed in the ny minimum stay or rements. If the facility, mission contract by or on seeking admission to the tawith the requirements of is not met as evidenced we and clinical record the facility staff failed to reficiary notification for the es for three of three sample, (Residents #132, or issue an advanced a discontinuing Medicare 132 on 7/14/202, Resident Resident #483 on owing the residents and/or is to appeal the discharge	F	582			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILO	TIPLE CONSTRUCTION	(X3) DATE	SURVEY
		495227	B, WING		- 1	C
	PROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP O 7300 FOREST AVE RICHMOND, VA 23226		05/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)		FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	The findings include  1. The facility staff fabeneficiary notice to discontinuing Medicathus not allowing the responsible party to services decision.  Resident #132 was a 5/25/2021 with diagnot limited to: depresprogressive state of memory function and accompanied by discobrain injury (happens other head injury caus (2).  The most recent MDS assessment reference the resident as scoring interview for mental seresident was severely cognitive decisions. The requiring extensive as staff member for most living.  The "Beneficiary Notice within the Last Six Most administrator on entra #132 was discontinue for 7/14/2021.	illed to issue an advanced Resident #132 upon are services on 7/14/202, resident and/or their appeal the discharge from admitted to the facility on oses that included but were sion, dementia (a mental decline, especially i judgement, often orientation.)(1), and traumatic when a bump, blow, joft, or ses damage to the brain.)  6 (minimum data set) are date of 9/7/2021, coded as a "5" on the BIMS (brief tatus) score, indicating the resident was coded as sistance on one or more to five activities of daily one a Resident Discharged on the Resident doff of Medicare A services record revealed a physical	FS	582	VDH/OLC	NOV 29 2021

						CWID IV	0.0000-0001
	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		E CONSTRUCTION		E SURVEY PLETED
		495227	B. WING			1	С
110100		493221	B. WING			10	/05/2021
	OF PROVIDER OR SUPPLIER  FPORT REHABILITATION AN	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) PREI TAC	FIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ìΧ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F .	highest practical level discharge from therape Further review of the evidence an "Advance given to the resident a representative.  An interview was concemember) #4, the direct 10/5/2021 at 10:36 a.r. process followed for is beneficiary notice for the Medicare services, OS to be issued 48 hours stated she had just stathrough the files in her the ones requested. O is to have a binder with where the resident were or stayed in the facility responsible party sign (name of computer sof stated she has started discharge from service before her start date at she would further look office.  OSM #4 returned on 10 stated she had looking office and cannot locate residents that were req Resident #132).  ASM (administrative stat director of nursing, was director of nursing, w	nented, "Resident is at of function. Agree with by services."  clinical record failed to ad Beneficiary Notice" was and/or their resident  fucted with OSM (other staff for of social services, on n. When asked about the suing an advanced discharging a resident from M #4 stated the letter has prior to discharge. OSM #4 and need to go office to see if she can find SM #4 stated her process in the letters and document into to; home, assisted living. After the resident or the letter it is scanned into the tware system). OSM #4 this process but the above is for Resident #132, was the facility. OSM #4 stated for this notification in her of the letters on any of the uested, (Including	F	582			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL		LE CONSTRUCTION	(X3) DATE COMP	SURVEY
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		495227		B. WING			1	05/2021
NAME OF P	ROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTPOR	RT REHABILITATION AND	D NURSING CENTER			ı	7300 FOREST AVE		
	T			لـــــ	L	RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	,	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 582	Continued From page	÷ 60		F	582	2		
		suing of the advanced						
		as requested at this time.						
	0- 40/E/2021 at 2:10	ACM #9 stated via						
		p.m. ASM #2 stated, via not have a policy related to						
		inced beneficiary notice.						
	_	·						
	No further information	was provided prior to exit.						
i	Non-Medical Reader, Chapman, page 124. (2) This information was following website:	y of Medical Terms for the 5th edition, Rothenberg and as obtained from the v/traumaticbraininjury.html.						
	•	led to issue an advanced					3	
	beneficiary notice to R	•	- 1					
	thus not allowing the re	eare services on 7/17/2021, esident and/or their				*		•
		opeal the discharge from	S*/5	16		20 12	0 .	
	services decision.	•						
	not limited to: Bipolar o	ses that included but were disorder (a mental disorder						· C
	The most recent MDS	(minimum data set)						
	assessment, a quarter		İ				1	
1		date of 9/24/2021, coded a "15" on the BIMS (brief	-					
		atus) score, indicating the						
		of making daily cognitive					1	
	decisions. The residen	t was coded as requiring						
,	limited assistance of or of his activities of daily	ne staff member for most						
1.	of his activities of daily	HVING.				1	- 9	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. 8UILD		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	8, WING			1	C 0/05/2021	
	ROVIDER OR SUPPLIER			73	REET ADDRESS, CITY, STATE, ZIP CODE 100 FOREST AVE ICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(XS) COMPLETION DATE	
F 582	Continued From page	61	F	582				
	within the Last Six Mo administrator on entra #13 was discontinued on 7/17/2021.  Review of the clinical any documentation re Medicare services. For record failed to evider Beneficiary Notice* wand/or their resident of the Medicare services and/or their resident of 10/5/2021 at 10:36 a. process followed for its beneficiary notice for Medicare services, Otto be issued 48 hours stated she had just stathrough the files in he the ones requested. Otto the the ones requested was resident we or stayed in the facility responsible party sign (name of computer so stated she has started discharge from service before her start date as she would further look office.  OSM #4 returned on stated she had looking the started of the st	as given to the resident epresentative.  ducted with OSM (other staff ctor of social services, on m. When asked about the ssuing an advanced discharging a resident from SM #4 stated the letter has prior to discharge. OSM #4 arted and need to go or office to see if she can find OSM #4 stated her process the the letters and document ent to; home, assisted living by. After the resident or the letter it is scanned into oftware system). OSM #4 did this process but the above es for Resident #13, was at the facility. OSM #4 stated of for this notification in her attent to the letters on any of the letters on any of the				2 747		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		3) DATE SURVEY COMPLETED	
		495227	B. WING			10/	) 05/2021	
NAME OF P	ROVIDER OR SUPPLIER	493221	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	107	75/2021	
				73	00 FOREST AVE			
WESTPOR	RT REHABILITATION ANI	O NURSING CENTER		RI	CHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE	
F 582	Continued From page	62	F	582				
	Resident #13).							
	•	of nursing, was made aware on 10/5/2021 at 1:58 p.m.				!		
	No further information	was provided prior to exit.						
		y of Medical Terms for the 5th edition, Rothenberg and						
	beneficiary notice to F discontinuing of Medic thus not allowing the r	care services on 9/16/2021,						
	7/29/2021 with diagno	dmitted to the facility on uses that included but were s, high blood pressure and eg.		362			27 3s	
	resident as scoring a interview for mental st resident is capable of decisions. The resider	rge assessment, coded the "14" on the BIMS (brief atus) score, indicating the making dally cognitive nt was coded as requiring one staff member for most						
	within the Last Six Mo administrator on entra	ce - Resident Discharged inths" form given to the ince documented Resident d off of Medicare A services						
	Review of the clinical	record failed to evidence	li .					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			60	<del></del>	С	
	<u> </u>	495227	B. WING_	<del></del>	10/05/2021	
	ROVIDER OR SUPPLIER RT REHABILITATION AND	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 582	any documentation re Medicare services. Fur record failed to evider Beneficiary Notice" was and/or their resident re An interview was concember) #4, the direct 10/5/2021 at 10:36 and process followed for its beneficiary notice for Medicare services, OS to be issued 48 hours stated she had just stated she had just stated she had just stated she had just stated she had just stated she had just stated she had just stated she had just stated she had started where the resident we or stayed in the facility responsible party sign (name of computer so stated she has started discharge from service before her start date as she would further look office.  OSM #4 returned on 1 stated she had looking office and cannot local residents that were received the start was received that were received the start was received that were recei	lated to the discontinuing of urther review of the clinical nee an "Advanced as given to the resident epresentative.  ducted with OSM (other staff stor of social services, on m. When asked about the ssuing an advanced discharging a resident from SM #4 stated the letter has prior to discharge. OSM #4 arted and need to go or office to see if she can find OSM #4 stated her process the letters and document ent to; home, assisted living or After the resident or the letter it is scanned into fitware system). OSM #4 I this process but the above es for Resident #483, was at the facility. OSM #4 stated in for this notification in her to 10/5/2021 at 11:49 a.m. and gin all of the piles in her te the letters on any of the	F 5	82		
F 584 SS=D		was provided prior to exit. le/Homelike Environment	F 5	Resident #72 remains in the center a bed rail was cleaned immediately upon notification of visual inspection.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		) DATE SURVEY COMPLETED
1			11, 55,25			С
		495227	8. WING_	<del>.</del>		10/05/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTPOR	RT REHABILITATION AND	NURSING CENTER		7300 FOREST AVE		
				RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG		SHOULD BE	(X5) COMPLETION DATE
	but not limited to receis supports for daily living. The facility must proving \$483.10(i)(1) A safe, of homelike environment use his or her personal possible.  (i) This includes ensuring receive care and serving physical layout of the findependence and document of the facility shall exist the protection of the reor theft.  §483.10(i)(2) Houseke services necessary to and comfortable interior shall be in good condition;  §483.10(i)(3) Clean be in good condition;  §483.10(i)(4) Private coresident room, as specified the services in all areas;  §483.10(i)(6) Comfortate levels. Facilities initially	onment.  th to a safe, clean, slike environment, including ving treatment and g safely.  de-clean, comfortable, and allowing the resident to all belongings to the extent sing that the resident can ces safely and that the facility maximizes resident es not pose a safety risk, ercise reasonable care for esident's property from loss eping and maintenance maintain a sanitary, orderly, or;  d and bath linens that are	F	2. All resident rooms will be a ensure environment is free or maintained in a clean manner. 3. DON or designee will educt housekeeping staff to ensure routine cleaning will include it resident rooms to ensure free substances and importance control. 4. DON or designee will audit resident's rooms to ensure cowith maintaining safe and cleenvironment weekly times 4 monthly times 2 to ensure for maintains a clean and homel environment. Any identified is be immediately corrected. Rereported to Quality Assurance for analysis and revision x 3 is 5. Date of compliance will be	f debris and r. cate all part of inspection of e of infection of ompliance an weeks and cility like ssues will be a committee e committee	f data.
		emperature range of /1 to				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRU	UCTION	(X3) DATE SURVEY COMPLETED	
						С	
		495227	B. WING			10/05/2021	
İ	ROVIDER OR SUPPLIER	NURSING CENTER		7300 FORE	DRESS, CITY, STATE, ZIP CODE ST AVE D, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B PROSS-REFERENCED TO THE APPROPRU DEFICIENCY)		
F 584	sound levels. This REQUIREMENT by: Based on observation document review and was determined that the maintain a clean, comenvironment for one of sample, Resident #72 The facility staff failed bed rail. On 9/28/21,1	is not met as evidenced is not met as evidenced in, staff interview, facility clinical record review, it he facility staff failed to fortable, homelike f 84 residents in the survey to clean Resident #72's	F	84			
	were not limited to dia osteoarthritis. Resider in status minimum dat	s diagnoses included but betes, dementia and nt #72's significant change a set assessment with an date of 8/5/21, coded the ills for daily decision					
	a.m., Resident #72 wa brown substance (app inch in length by a half observed on the left be On 9/30/21 at 8:49 a.n conducted with OSM ( director of housekeepi rails should be cleaned	ed rail.					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER  WESTPORT REHABILITATION AND NURSING CENTER  SISSAMARY STREMEM FOR PROPISES AND PROVIDERS (EACH RESIDENCY MUSTER PRECEDED BY RILL RESULATORY OR LISC IDENTIFYING INFORMATION)  FOR PROVIDER THAN OR CORRECTION ACCURATE PRECEDED BY RILL RESULATORY OR LISC IDENTIFYING INFORMATION)  F 584  Continued From page 66  #77's left bed rail. OSM #3 stated she did not know what the substance was but it looked like dried coffee or dried chocolate loc cream. OSM #3 stated the drifty der fall was unacceptable and she would have it taken care of.  On 104/27 at 11:25 a.m., ASM (administrative staff member) #1 (the administratior) and ASM #2 (the director of nursing) were made aware of the above concern.  The facility policy titled, "Cleaning and Disinfecting Residents' Rooms" documented, "7. Clean personal use items (e.g. lights, phones, call belds, bedralls, etc.) with disinfectant solution at least twice weekly."  No further information was presented prior to exit. Great two weekly.  No further information was presented prior to exit. Great two provides and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimination or reprisal and without fear of discrimin		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	RIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
WESTPORT REHABILITATION AND NURSING CENTER    Company   Substance			495227	B. WING_		10/05/2021
PRETIX TAG  F 584  Continued From page 66  #72's left bed rail. OSM #3 stated she did not know what the substance was but it looked like dried cofee or dried chocolate loc cream. OSM #3 stated the dirty bed rail was unacceptable and she would have it taken care of.  On 10/4/21 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.  The facility policy titled, "Cleaning and Disinfecting Residents' Rooms" documented, "7. Clean personal use items (e.g. lights, phones, call bells, bedrails, etc.) with disinfectant solution at least twice weekly."  No further information was presented prior to exit. Grievences  S=50  CFR(s): 483.10(j)(1)-(4)  §483.10(j) Grievances. §483.10(j) Grievances without discrimination or reprisal, Such grievances to the facility or other agency or entity that hears grievances without fear of discrimination or reprisal, such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished as well as that which has not been furnished as well as that which has not been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.  §483.10(j)(2) The resident has the right to and the facility wast make prompt efforts by the facility to respect to a regarding their LTC facility stay.  §483.10(j)(2) The resident has the right to and the facility wast make prompt efforts by the facility to resolve grievances and timely resolution.			D NURSING CENTER		7300 FOREST AVE	
#72's left bed rail. OSM #3 stated she did not know what the substance was but it looked like dried coffee or dried chocolate loc cream. OSM #3 stated the dirty bed rail was unacceptable and she would have it taken care of.  On 10/4/21 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.  The facility policy titled, "Cleaning and Disinfecting Residents' Rooms' documented, "7. Clean personal use items (e.g. lights, phones, call befls, bedrails, etc.) with disinfectant solution at least twice weekly.'  No further information was presented prior to exit. Grievances CFR(s): 483.10()(1)-(4)  \$483.10()(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished as well as that which has not been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.  \$483.10()(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI)	X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETION
	F 585	#72's left bed rail. Os know what the substa dried coffee or dried of #3 stated the dirty be she would have it take. On 10/4/21 at 11:25 a staff member) #1 (the director of nursin above concern.  The facility policy title Disinfecting Resident Clean personal use it bells, bedrails, etc.) wheast twice weekly."  No further information Grievances CFR(s): 483.10(j)(1) The resignity grievances to the fact that hears grievances reprisal and without for reprisal. Such grievances to care and the furnished as well as the furnished as well as the furnished, the behavior residents, and other of facility stay.  §483.10(j)(2) The residents must make processolve grievances the substantial processory and the person of the facility must make processory grievances the substantial processory grievances the substantial processory grievances the substantial processory grievances the substantial processory grievances the substantial processory grievances the substantial processory grievances the substantial processory grievances the substantial processory grievances the substantial processory grievances the substantial processory grievances the substantial processory grievances the substantial processory grievances the substantial processory grievances the substantial processory grievances the substantial processory grievances the processory grievances the grievance grievances the grievance grievances the grievance grievances the grievance grievance grievance grievances the grievanc	SM #3 stated she did not unce was but it looked like chocolate ice cream. OSM dirait was unacceptable and en care of.  I.m., ASM (administrative endministrator) and ASM #2 g) were made aware of the direct was a discovered aware of the direct was endemanded aware of the direct was endemanded aware of the direct was endemanded aware of the direct was presented prior to exit.  (4)  S. ident has the right to voice dility or other agency or entity without discrimination or ear of discrimination or ear of discrimination or ear of discrimination or ear of staff and of other concerns regarding their LTC dident has the right to and the compt efforts by the facility to be resident may have, in		1. Resident #153 remains in center, upon notification of a finding of reported grievance missing memorial t-shirt; facility-initiated grievance wir placement of item prior to accompletion of inspection.  2. Review of all grievances completed from 09/01/2021 ensure follow-up and resolut stated grievance.  3. DON or designee will edu facility staff on the policy retareporting to grievances and	uditors for th iditors' to cate all ated to

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMPI	
ANDFLATO	COMECHON	(DENT) (ON (ON (ON ))	A, BUILD	ING _		(	,
		495227	B, WING			1	05/2021
NAME OF P	ROVIDER OR SUPPLIER	<u></u>	.k	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
WESTSON	T OF LADY ITATION AND	DANIDONG CENTER		7	300 FOREST AVE		
WESTPOR	RT REHABILITATION ANI	D NURSING CENTER		F	RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION DATE
F 585	on how to file a grieval to the resident.  §483.10(j)(4) The faci grievance policy to en of all grievances regal contained in this para provider must give a contained in this para provider must give a contained in this para provider must give a contained in the resident. The grinclude:  (i) Notifying resident in postings in prominent facility of the right to form (meaning spoken) or grievances anonymous of the grievance offician be filed, that is, the grievance; and the contained written degrievance; and the contained written degrievance; and the contained that is, the period of the grievance o	lity must make information ance or complaint available  lity must establish a asure the prompt resolution rding the residents' rights graph. Upon request, the copy of the grievance policy rievance policy must andividually or through a locations throughout the sile grievances orally in writing; the right to file usly; the contact information al with whom a grievance is or her name, business email) and business phone a expected time frame for a for the grievance; the right cision regarding his or her information of with whom grievances may pertinent State agency, Organization, State Surveying-Term Care Ombudsman and advocacy system; ance Official who is seeing the grievance process, a grievances through to their any necessary investigations ining the confidentiality of all	F	585	4.DON or designee will audit 10% of all grievances to ensure resolution and follow-up completed weekly times 4 weeks and monthly times 2 to ensure facility maintains proportification. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance Committee for analysis and revision x 3 months.  5. Date of compliance will be	er	1/19/21
FORM CMS-256	7(02-99) Previous Versions Obs	olele Event ID: JFVL1	1	Fa	acility ID: VA0270 If continu	ation sheel	Page 68 of 254

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		MPLETED C
		495227	B. WING			0/05/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER	730	EET ADORESS, CITY, STATE, ZIP COI 0 FOREST AVE :HMOND, VA 23226		
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F 585	necessary in light of s (iii) As necessary, tak prevent further potent right while the alleged investigated; (iv) Consistent with §- reporting all alleged v abuse, including injur and/or misappropriati anyone furnishing set provider, to the admir as required by State I (v) Ensuring that all w include the date the g summary statement of the steps taken to inv summary of the pertir regarding the resident as to whether the gric confirmed, any correct taken by the facility a and the date the writt (vi) Taking appropriat or if an outside entity the State Survey Age Organization, or local confirms a violation for rights within its area of vii) Maintaining evide result of all grievance 3 years from the issu decision. This REQUIREMENT by: Based on resident in clinical record review	specific allegations; sing immediate action to tial violations of any resident d violation is being  483.12(c)(1), immediately riolations involving neglect, ies of unknown source, on of resident property, by rvices on behalf of the histrator of the provider; and daw; written grievance decisions grievance was received, a of the resident's grievance, restigate the grievance, a ment findings or conclusions of sourcerns(s), a statement evance was confirmed or not cive action taken or to be as a result of the grievance, the corrective action in the law if the alleged violation as is confirmed by the facility having jurisdiction, such as ancy, Quality Improvement I law enforcement agency or any of these residents'	F 585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495227	B. WING			C (05/2021	
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION A	1D NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 100 FOREST AVE ICHMOND, VA 23226	 ø:	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
resolve a reported g residents in the surv The facility staff falle #153's verbal grieval clothing item was promade to resolve the The findings include: Resident #153 was a diagnoses including disorder (1) and diab most recent MDS (m assessment with an date) of 9/13/2021, c scoring a 12 on the b status (BIMS) assess impaired for making On 9/28/2021 at apprinterview was conduct Resident #153 stated sister's funeral in Fet memorial t-shirt with which meant a lot to returned from being stated that they had a LPN (licensed practic manager several time March but had never facility other than the The comprehensive documented in part, "	d make prompt efforts to rievance for one of 84 by sample, Resident #153.  If to evidence Resident rice regarding a missing amptly acted upon and efforts resident's grievance.  Idmitted to the facility with put not limited to bipolar etes (2). Resident #153's inimum data set), a quarterly ARD (assessment reference oded Resident #153 as rief interview for mental sment, 12- being moderately daily decisions.  In that they had attended their regarders at the facility had not evashed. Resident #153 eported the t-shirt missing to all nurse) #10, the unit nurse is in late February and gotten a response from the y were looking for it.	F	585			

PRINTED: 10/19/2021
FORM APPROVED
OMB NO. 0938-0391

ULTIPLE CONSTRUCTION (X3) DATE SURVEY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	NG	TRUCTION	(X3	C C COMPLETED	
		495227	B. WING				10/05/2021	
	ROVIDER OR SUPPLIER	D NURSING CENTER		7300 FO	ADDRESS, CITY, STATE, ZIP CODE REST AVE OND, VA 23226	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEF(CIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 585	disorder and treatmer Recently younger sist Initiated: 02/11/2021, The progress notes for documented in part, "Note Text: F/U (follow to funeral COVID-19  Review of the facility through the present for grievances regarding Resident #153.  On 9/30/2021 at 1:10 conducted with LPN in LPN in the present for the present f	medication, use of tion. Diagnosis of Bipolar nt resistant depression. ter suddenly died. Date Revision on: 09/27/2021."  or Resident #153 (2/26/2021 19:05 (7:05 p.m.) (2 up) LOA (leave of absence) (3) screening"  grievances dated 1/1/2021 alled to evidence any missing clothing for (2 p.m., an interview was #10, the unit nurse manager. (3 when residents reported led out a concern form, and notified the the item. LPN #10 stated to found they notified social ation to reimburse the LPN #10 stated that there he for grievance resolution on the missing item. (4 they were aware of Resident 1 with her sister's photo on it. (5 they could not put a value on the searched for it and were PN #10 stated that they had not over to the former social grievance after they had as not sure of the resolution.	F	585				
	Un 10/5/2021 at appi	roximately 9:15 a.m., a		1				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495227	B, WING			10/	05/2021
	ROVIDER OR SUPPLIER RT REHABILITATION AND	NURSING CENTER	:	730(	EET ADDRESS, CITY, STATE, ZIP CODE D FOREST AVE 'HMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIM DEFICIENCY)		(X5) COMPLETION DATE
	request was made to member) #2, the direct policy on grievance retailed April 2017 docu and their representating grievances, either oral staff or to the agency of grievances, either oral staff or to the agency of grievances (e.g., the Stadministrator and staff resolve grievances to resident and/or represcomplaints or recommercial and for family ground resident or family ground resident care in the fact Actions on such issues writing, including a rating responseUpon receivant responseUpon receivant responseUpon receivant response five (5) working days of and/or complaintThe files, investigated and on file for a minimum of issuance of the grievant files, investigated and on file for a minimum of issuance of the grievant files, investigated and files, investigated and on file for a minimum of issuance of the grievant files, investigated and files, investigated and files of the grievant files, investigated and on file for a minimum of issuance of the grievant files, investigated and files of the grievant files. The administrator and the grievant files of the grievant files of the grievant files of the grievant files of the grievant files of the grievant files of the grievant files. The grievant files of t	ASM (administrative staff stor of nursing for the facility solution.  evances/Complaints, Filing" mented in part, "Residents we have the right to fite ally or in writing, to the facility designated to hear state Ombudsman). The fewill make prompt efforts to the satisfaction of the entativeAll grievances, endations stemming from a pse concerning issues of cility will be considered, as will be responded to in some for the pt of a grievance and/or and submit a written to the Administrator within a freceiving the grievance reported will be maintained of three years from the nace decision"  eximately 4:30 p.m., ASM and ASM #2, the director of the concern.  was presented prior to exit.	F	585			
	manic-depressive illne						<del>\$</del> 5.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495227	B, WING	_		10/	05/2021
	ROVIDER OR SUPPLIER	NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE ICHMOND, VA 23226		
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	mood, energy, activity the ability to carry out information is taken for https://www.nimh.nih.gorder/index.shtml.  2. Diabetes mellitus: the body cannot regulate blood. This information website: https://www.nlm.nih.go/01214.htm.  3. COVID-19 is cause SARS-CoV-2. Corona viruses that are communities that are communities that are communities that are communities that are communities that are communities that are communities that are communities that are communities that are communities that are communities that are communities that are communities to an infection of the coronaviruses can infective and SARS-CoV, and incauses COVID-19. The betacoronavirus, like the SARS-CoV. All three corigins in bats. The seare similar to the one to suggesting a likely sing this virus from an anime exact source of this virus from an anime exact source of this virus information was obtain https://www.cdc.gov/com/#How-COVID-19-Sp. Right to be Free from I	levels, concentration, and day-to-day tasks." This om the website gov/health/topics/bipolar-dis  A chronic disease in which ate the amount of sugar in lation was obtained from ov/medlineplus/ency/article/  and by a coronavirus called viruses are a large family of on in people and may limals, including carnels, Rarely, animal act people and then spread occurred with MERS-CoV low with the virus that the SARS-CoV-2 virus is a MERS-CoV and of these viruses have their quences from U.S. patients that China initially posted, gle, recent emergence of last reservoir. However, the last is unknown. This led from the website: bronavirus/2019-ncov/faq.ht oreads Physical Restraints		585	1. Resident #502 no longer resides	in	
	CFR(s): 483.10(e)(1), 6 §483.10(e) Respect ar	483.12(a)(2)			Resident #502 no longer resides the facility.     All residents are at risk and will be evaluated for use of physical restrains.	e	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		ONSTRUCTION		SURVEY
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1		495227	B, WING			10/05/2021	
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
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WESTPOR	RT REHABILITATION AN	D NURSING CENTER		RIC	HMOND, VA 23226		
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	required to treat the reconsistent with §483.12 The resident has the reglect, misapproprial and exploitation as de includes but is not limicorporal punishment, any physical or chemitreat the resident's mediated with the resident's mediated. The facility §483.12(a) (2) Ensure from physical or chemitreat of discipline are not required to treasymptoms. When the indicated, the facility indicated, the facility indicated, the facility indicated, the facility indicated occurrent ongoing represtraints. This REQUIREMENT by: Based on staff interview, clinical record a complaint investigation the facility staff failed the being physically restrain the survey sample, in the survey sample sample.	the to be free from any restraints imposed for or convenience, and not esident's medical symptoms, 12(a)(2).  right to be free from abuse, tion of resident property, fined in this subpart. This fited to freedom from involuntary seclusion and cal restraint not required to edical symptoms.  Thust-  that the resident is free ical restraints imposed for or convenience and that at the resident's medical use of restraints is must use the least restrictive it amount of time and evaluation of the need for is not met as evidenced ew, facility document review, and in the course of on, it was determined that o prevent a resident from ined for one of 84 residents Resident #502. On 5/6/21, scovered lying in bed, with	F	604	3. DON or designee will educate all facility nursing staff on centers policifor restraint use.  4. DON or designee will audit 10% or residents to ascertain free from physical restraint weekly times 4 we and monthly times 2 to ensure facility staff maintain a respectful and digniful environment, free of unnecessary restraint. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision months.  5. Date of compliance will be	eks ty fied be	11/19/21
	The findings include:		1				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULI A, BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED C	
		495227	8, WING			10/05/20	121
	ROVIDER OR SUPPLIER	D NURSING CENTER	Y.	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	<u> </u>		
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F 604	Continued From page	74	F	604			
** ** **	4/27/16, and most rec with diagnoses includ and arthritis. She was on 6/12/21. On the modata set), a quarterly (assessment reference resident was coded a impaired for making discored one out of 15 for mental status). She placed in physical resperiod.  A review of Resident revealed the following 5/6/21: "[Resident #50 wristband attached to article of clothing. The and a skin assessment integrity issues noted.  A review of Resident plan dated 5/11/16 and in part: "At risk for chadiagnosis of dementia Assess for physical may precipitate chang revealed no update replaced in physical resubmitted by the facili 5/11/21 revealed, in pobserved [Resident # attached to the bedra Investigation findings	s being severely cognitively ally decisions, having on the BIMS (brief interview e was coded as not being traints during the look back #502's clinical record progress note, dated 02] was observed with the arm rail of her bed via existband was removed at was completed. No #502's comprehensive care dupdated 6/26/16 revealed, anges in mood related to a, atypical psychosis fenvironmental changes that ge in mood." The review egarding the resident being traints.  RI (facility reported incident) if to the state agency on art: "On [5/6/21], staff					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SU COMPLE	
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L		495227	B. WING			10/05	/2021
i	PROVIDER OR SUPPLIER	D NURSING CENTER	73	TREET ADDRESS, CITY, STATE, ZIP CO 300 FOREST AVE ICHMOND, VA 23226	300		
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F 604	to ascertain feelings of area of concern. All refor signs of injury, nor well-being will continu. Social Worker. Care is reflect appropriate car substantiated however ongoing."  On 9/30/21 at 10:27 a staff member) #4, the interviewed. He stated many years. ASM #4 with the circumstance being tied to her bed, perhaps a supervisor.  On 9/30/21 at 11:47 a assistant) #8 was intervised was in the rotation of the resident #502. CNA went into the resident bathing her. She state arm at the wrist tied thin black piece of mather wrist, and tied to the immediately notified the management. CNA #8 not demonstrate any stated on 5/6/21, a CN that Resident #502 was #7 stated she assessed danger, and after considering, she then removed.	of safety, all reported no asidents on unit assessed to-observed. Psychosocial te to be followed up on by Plan reviewed and revised to reThis allegation is an investigation remains to a management of the medical director, was all the knew Resident #502 for stated he was not familiar is regarding Resident #502's but he believed a nurse and were terminated as a result.  The continuation of the stated she conditions to see the condition of the saw the resident's left of the bed rail. She stated a terial was wrapped around the bed. She stated she is taked a terial was wrapped around the bed. She stated she is nurse, who notified upper is stated Resident #502 did tigns of injury.  The condition of the same of the same of the period of the same of the same of the stated and the same of the	F 604				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		CONSTRUCTION		SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	100	03/2021
WESTPO	RT REHABILITATION AN	D NURSING CENTER		730	00 FOREST AVE CHMOND, VA 23226		
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F 604	Continued From page	<del>.</del> 76	F	604			
	the bed rail looked a c sweatpants. LPN #7 s wrist was "a little red," revealed the resident	drawstring from a pair of stated Resident #502's left but her assessment was not experiencing any called the resident's family					
	staff member) #2, the interviewed. When as determined who had a 5/6/21, she stated the both the overnight nur temporary agency sta allowed to return to the licensing board for been in the facility with	estrained Resident #502 on y had not. ASM #2 stated se and CNA were					-
	A review of the facility revealed, in part: "Res for the safety and well and only after other all unsuccessfully. Restraints shall only bresident's medical syndiscipline or staff convervention of falls. When the use of restraints restrictive alternative warmount of time necess re-evaluation for the nedocumented5. Restriif/when the resident has	policy, "Use of Restraints," traints shall only be used being of the resident(s) tematives have been tried the used to treat the temptom(s) and never for ten-ience, or for the thints is indicated, the least thints is indicated, the least the used for the least the used for the least the used for restraints will be the used for restraints will be the used ints may only be used		The statement of the st		TOUT 62 AON	RECEIVED

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495227	B, WING		C 10/05/2021
1	PROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 604	required to: Treat the the resident's safety, attain the highest leve psychological well-beil No further information Complaint Deficiency	ntion AND a restraint is medical symptom; Protect and Help the resident of his/her physical or ng."  was provided prior to exit.	F 60	1. Resident #111 and #72 remain in	the
	(A) The transfer or dis resident's welfare and cannot be met in the fig.) The transfer or dis because the resident's sufficiently so the resident's sufficiently so the resident's services provided by the continuous of the resident; (D) The safety of individual of the resident; (D) The health of individual of the resident has far appropriate notice, to punder Medicare or Medicare or Medicare or Medicare or Medicare, the the Medicare or Medicare, to payment or after the the Medicare or Medicare, to payment or after the themselves to payment refuses to payment refuses to payment or after the payment or after the payment or after the themselves to payment refuses to payment or after the payment or	nd discharge- requirements- rmit each resident to and not transfer or from the facility unless- charge is necessary for the the resident's needs acility; charge is appropriate thealth has improved dent no longer needs the ne facility; iduals in the facility is clinical or behavioral iduals in the facility would red; ailed, after reasonable and boay for (or to have paid dicaid) a stay at the facility. the resident does not baperwork for third party	F 62	center. Due to the nature of requeste evidence facility is not able to rectify past event.  2. All residents discharged to hospital reviewed to ascertain physician documentation indicates need for trate to hospital and all supporting documentation accompanies resident receiving facility.  3. DON or designee will educate all nursing staff on the documentation of at time of transfer to include, comprehensive care plan goals, advidirectives, special care instructions, resident representative information adischarge summary. Physicians will education to ensure provider documentation indicate necessity of transfer.  4. DON or designee will audit 10% or residents transferred to hospital to ecompliance of mandatory documentation was completed week times 4 weeks and monthly times 2 lensure facility indicates reason neces for transfer and supporting paperwork transferred to maintain continuum of Any identified issues will be immedia corrected. Results will be reported to Quality Assurance committee for and and revision x 3 months.  5. Date of compliance will be	on al ansfer at to facility equired ance and receive  f all nsure ation ly o ssary ki is care, stely

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
		495227	B, WING			10/05/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER	-1	STREET ADDRESS, CITY, STATE, ZIP 7300 FOREST AVE RICHMOND, VA 23226	CODE	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			D BY FULL PREFIX (EACH CORRECTIVE ACTION SH		
F 622	admission to a facility resident only allowable or (F) The facility ceases (ii) The facility may not resident while the app § 431.230 of this charge notice from 431.220(a)(3) of this edischarge notice from 431.220(a)(3) of this edischarge or transfer or safety of the reside facility. The facility methat failure to transfer §483.15(c)(2) Docum When the facility transresident under any of in paragraphs (c)(1)(i) section, the facility more discharge is documedical record and a communicated to the institution or provider. (i) Documentation in the facility may include:  (A) The basis for the finite include:  (B) In the case of parasection, the specific rebe met, facility attempneeds, and the service facility to meet the net (ii) The documentation (2)(i) of this section met. The resident's physical service in the resident's physical service in the resident's physical service in the resident's physical service in the resident's physical service in the resident's physical service in the resident's physical service in the resident's physical service in the facility attempneeds, and the service facility to meet the net (ii) The documentation (2)(i) of this section methatical service in the resident's physical service in the resident's physical service in the facility attempneeds in the resident's physical service in the resident's phy	the facility may charge a le charges under Medicaid; so to operate. In transfer or discharge the peal is pending, pursuant to oter, when a resident ght to appeal a transfer or it the facility pursuant to § chapter, unless the failure to would endanger the health ent or other individuals in the lust document the danger or discharge would pose.  The circumstances specified (A) through (F) of this lust ensure that the transfer mented in the resident's peropriate information is receiving health care  The resident's medical record transfer per paragraph (c)(1) (a) (b) (b) (b) (c) (c) (d) (d) (e) (e) (e) (e) (e) (e) (e) (e) (e) (e	L.	622		
FORM CMS-256	7(02-99) Previous Versions Obs	colete Event ID: JFVL	11	Facility ID: VA0270	If continuation s	heet Page 79 of 254

STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	1 '		CONSTRUCTION	(X3) DATE S	
AND I DAN OF	ONNEOTION		A, BUILU	OM	· · · · · · · · · · · · · · · · · · ·	c	;
		495227	B. WING			10/0	5/2021
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER				73	REET ADDRESS, CITY, STATE, ZIP CODE 900 FOREST AVE ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)				(XS) COMPLETION DATE
F 622	necessary under parathis section.  (iii) Information provide must include a minime (A) Contact information responsible for the cat (B) Resident represent contact information (C) Advance Directive (D) All special instruction on the case of the cas	transfer or discharge is transfer or discharge is transfer or discharge is transfer or discharge is transferred to the hospital sician failed to document the service available at the east the resident's needs.		622			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES					<u></u>	OMB NO	). 0938-0391
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495227	B, WING			10/	05/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION)		IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622	2. The facility staff fail all required information hospital staff when Reform to the hospital on 7/18. The findings include:  1.a. Resident #111 was 5/24/21. Resident #11 were not limited to dia anxiety disorder. Resiminium data set assassessment reference resident's cognition as Review of Resident #revealed a nurse's not documented Resident hospital due to aggres Further review of Resident hospital due to aggres Further review of Resident hospital due to aggres failed to reveal physic regarding the basis for resident needs that coattempts to meet their service available at the the needs of Resident On 9/30/21 at 10:27 a conducted with LPN (LPN #7 was asked if the document why a resident. LPN #7 stat The providers that do and name of one nurs not name Resident #1	ed to provide evidence that in was provided to the esident #72 was transferred 3/21.  It is admitted to the facility on 11's diagnoses included but obetes, dementia and ident #111's quarterly ressment with an edate of 8/28/21, coded the is severely impaired.  It is clinical record to de dated 8/30/21, that it #111 was transferred to the esive behaviors and a fall. Ident #111's clinical record ian documentation rethe transfer, the specific build not be met, facility resident needs and the ereceiving facility to meet if #111.  Im., an interview was incensed practical nurse) #7. The facility physicians the transferred to the ed, "In my experience, yes, are (name of one physician e practitioner). LPN #7 did	F	622			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495227	8. WING			1 -	5/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622	(the director of nursin above concern.  The facility policy title Responsibilities" doct Resident Discharges Attending Physician was pertinent medical disciplation of the discharge of the discharge of the discharge of the discharge of the discharge of the discharge of the discharge of the discharge of the discharge of the discharge of the discharge of the discharge of the discharge of the discharge of the discharge of the discharge discharge of the discharge discharge discharge of the discharge	d, "Attending Physician umented, "Supporting and Transfers3. The will provide a summary of charge information within 30 transfer of a resident."  In was presented prior to exit.  In was presented prior to exit.  In the stransferred to the Further review of Resident failed to reveal dence that all required physician contact representative contact instructions for ongoing care, and comprehensive care plan to the receiving hospital  a.m., an interview was (licensed practical nurse) #7.  Is sheet, bed hold policy,	F	622			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

TATEMENT OF DESICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A, BUILDING			(X3) DATE SURVEY COMPLETED			
		10-000	B, WING				C 10/05/2021	
NAME OF F		495227	B. WING		EET ADDRESS, CITY, STATE, ZIP CODE		10/05/2021	-
	ROVIDER OR SUPPLIER RT REHABILITATION ANI	D NURSING CENTER		7300	FOREST AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE	(X5) COMPLETE DATE	
F 622	(the director of nursin above concern.  The facility policy title Emergency" documer necessary to make as discharge to a hospits our facility will implem procedures:  a. Notify the resident'. b. Notify the receiving being made; c. Prepare the resident. Prepare a transfer resident; e. Notify the representable family member; f. Assist in obtaining tig. Others as appropri	d, "Transfer or Discharge, thed, "4. Should it become in emergency transfer or all or other related institution, tent the following is Attending Physician; if facility that the transfer is int for transfer; form to send with the tative (sponsor) or other transportation; and ate or as necessary."	F	622				
	2. Resident #72 was a 3/9/15. Resident #72 were not limited to discosteoarthritis. Reside in status minimum da assessment reference resident's cognitive standing as moderately.  Review of Resident # a nurse's note dated resident was transferright hip dislocation. #72's clinical record formation, including	ant #72's significant change to set assessment with an elected of 8/5/21, coded the kills for daily decision y impaired.  72's clinical record revealed 7/18/21 that documented the red to the hospital due to a Further review of Resident alled to reveal dence that all required		The second secon				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495227	B, WING			ł	C 05/2021
NAME OF P	ROVIDER OR SUPPLIER	77.5461		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	107	03/2021
I NAME OF F	NOVIDER ON SOFFEIER				FOREST AVE		
WESTPO	RT REHABILITATION AND	NURSING CENTER			HMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				(XS) COMPLETION DATE
F 623 SS=D	Continued From page information, special in advance directives an goals, was provided to On 9/30/21 at 10:37 a conducted with LPN (I LPN #7 stated a face advance directive, con (Situation-Background ation) form, history an orders, the most recent notice, a copy of the conform should be sent to resident is transferred stated this is evidence on 10/4/21 at 11:25 a staff member) #1 (the director of nursing above concern.  No further information Notice Requirements I CFR(s): 483.15(c)(3)-(3)-(3)-(3)-(3)-(3)-(3)-(3)-(3)-(3)	structions for ongoing care, d comprehensive care plan to the hospital staff.  .m., an interview was iicensed practical nurse) #7. sheet, bed hold policy, de status, SBAR d-Assessment-Recommend d physical, physician are plan goals and transfer are plan goals and transfer to the hospital. LPN #7 dby a nurse's note.  .m., ASM (administrative administrator) and ASM #2 g) were made aware of the was presented prior to exit. Before Transfer/Discharge (6)(8)  refore transfer.  ers or discharges a just- and the resident's et transfer or discharge and		622	1. Residents #111. #19 and #72 remains the center. Due to the nature of requestive evidence facility is not able to establish past event.  2. All residents discharged/transferre hospital reviewed to ensure proof of documentation of written notification and ombudsman of all transfers since	ested sh on d to proper to RR	
	the reasons for the molanguage and manner facility must send a corepresentative of the Cong-Term Care Ombodis) Record the reasons discharge in the reside accordance with paragraphs.	they understand. The py of the notice to a office of the State udsman. s for the transfer or			10/05/2021.  3. DON or designee will educate all fa admission and discharge planning starequirements for providing written notification to RR and ombudsman of transfers to hospital with proof maintain facility records.	acility aff on	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE (	CONSTRUCTION		DATE SURVEY COMPLETED
	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	ING	<del></del>		С
		495227	B. WING				10/05/2021
NAME OF B	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				73	00 FOREST AVE		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		RI	CHMOND, VA 23226		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF COR	RECTION	(X5) COMPLETION
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
F 623	Continued From page and (iii) Include in the not paragraph (c)(5) of the \$483.15(c)(4) Timing (i) Except as specifie (c)(8) of this section, discharge required under by the facility a resident is transferred (ii) Notice must be more transfer or discharger end under this section; (B) The health of individual be endangered under this section; (C) The resident's health of individual this section; (C) The resident's health of individual this section; (C) The resident's health of individual this section; (C) The resident's health of individual this section; (C) The resident's health of individual this section; (C) The resident has not under paragraph (c)(E) A resident has not days.  \$483.15(c)(5) Content notice specified in paragraph (c)(i) The reason for transferred or discharge including the folicituding the name, and telephone numbers.	ice the items described in his section.  If of the notice. If in paragraphs (c)(4)(ii) and the notice of transfer or under this section must be at least 30 days before the dor discharged. If it is as soon as practicable excharge when-ividuals in the facility would be paragraph (c)(1)(i)(C) of ividuals in the facility would be paragraph (c)(1)(i)(D) of ividuals in the facility would be paragraph (c)(1)(i)(D) of ividuals in the facility would be paragraph (c)(1)(i)(D) of ividuals in the facility would be paragraph (c)(1)(i)(D) of ividuals in the facility would be paragraph (c)(1)(i)(D) of ividuals in the facility would be paragraph (c)(1)(i)(D) of ividuals in the facility for ividuals in the facility for interested in the facility for 30 ints of the notice. The written aragraph (c)(3) of this section owing:  In the notice. The written aragraph (c)(3) of this section owing:  If the notice is a section is a section of the notice is a section owing:  If the notice is a section is a section owing:  If the notice is a section is a section owing:  If the notice is a section is a section owing:  If the notice is a section is a section owing:  If the notice is a section is a section owing:  If the notice is a section is a section owing:  If the notice is a section is a section owing:  If the notice is a section is a section owing:  If the notice is a section is a section owing:  If the notice is a section is a section owing:  If the notice is a section is a section is a section owing:  If the notice is a section is a sectio	F	623	4. DON or designee will audit residents transferred to hosp compliance of mandatory dot and written notification to RR ombudsman of transfer was weekly tirnes 4 weeks and m 2 to ensure facility maintains notification. Any identified iss immediately corrected. Resureported to Quality Assuranc for analysis and revision x 3 5. Date of compliance will be	ital to ensur cumentation and completed conthly times proper sues will be lits will be se committed months.	re 1
	receives such reque	ests; and information on how					
1	49					If continuati	ion sheet Page 85 of 2

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/19/2021 FORM APPROVED OMB NO. 0938-0391

CENTER	MEDICAID SERVICES		OMB NO. 0938-0391				
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495227	B. WING			10/05	/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER	3	730	EET ADDRESS, CITY, STATE, ZIP CODE 0 FOREST AVE :HMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE i	(X5) COMPLÉTION DATE
F 623	completing the form a hearing request; (v) The name, addrest telephone number of Long-Term Care Omlow (vi) For nursing facility and developmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities of the Developmental disability. Colification or related disemail address and the agency responsible for advocacy of individual established under the for Mentally III Individually Individually Individually Individually Individually Individually Individually Individually Individually	orm and assistance in and submitting the appeal ass (mailing and email) and the Office of the State budsman; by residents with intellectual isabilities or related ag and email address and the agency responsible for evocacy of individuals with a dities established under Part at Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and the residents with a mental sabilities, the mailing and dephone number of the or the protection and als with a mental disorder a Protection and Advocacy luals Act.	F	623			

Event ID: JFVL11

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		NSTRUCTION	:	(X3) DATE SURVEY COMPLETED	
		495227	B. WING				1	C :
NAME OF F	PROVIDER OR SUPPLIER	*3444	0,	STREE	ET ADDRESS, CITY, STATE,	ZIP CODE	<u>( 10/</u>	05/2021
WESTPO	RT REHABILITATION AND	O NURSING CENTER			FOREST AVE MOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRECTIVE CROSS-REFERENCED	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
	relocation of the reside 483.70(I). This REQUIREMENT by: Based on staff interviand clinical record revithe facility staff failed to transfer to a RR (reside the ombudsman for this survey sample, Reside 1. Resident #111 was on 8/30/21 and on 9/6 failed to provide writte to the resident's representative to the resident's representative.  2. Resident #72 was transfer to the transfer	is not met as evidenced  ew, facility document review iew, it was determined that to provide written notice of lent representative) and/or ree of 84 residents in the ents #111, #72 and #19.  transferred to the hospital ///21. A. The facility staff in notification of the transfer sentative and the 30//21 transfer, and B. failed ication of the transfer to the ve for the 9/6/21 transfer.  Transferred to the hospital on taff failed to provide written size to the resident's  ansferred to the hospital on taff failed to provide written size to the ombudsman  as admitted to the facility on 1's diagnoses included but betes, dementia and dent #111's quarterly essment with an date of 8/28/21, coded the	F	623				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/19/2021 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER  WESTPORT REHABILITATION AND NURSING CENTER  RICHMOND, WA 23228  SUMMARY STATEMENT OF DEFICIENCIES  REACH DEPRICISION OF ILEA DEPRICE OF PULL, REGULATORY OR ILEA DEPRICED BY PULL, REGULATORY OR ILEA DEPRICE AND ADMINISTED PRECEDED BY PULL, REGULATORY OR ILEA DEPRICED AND ADMINISTED PRECEDED BY PULL, REGULATORY OR ILEA DEPRICED AND ADMINISTED PRECEDED BY PULL, REGULATORY OR ILEA DEPRICED AND ADMINISTED PRECEDED BY PULL, REGULATORY OR ILEA DEPRICED AND ADMINISTED PRECEDED BY PULL, REGULATORY OR ILEA DEPRICED BY PULL, REGULATORY OR ILEA DEPRICED BY PULL, REGULATORY OR ILEA DEPRICED BY PULL, REGULATORY OR ILEA DEPRICED BY PROVIDED BY ADMINISTED BY ADMINISTRATION OF THE APPROPRIATE COMMENTION OF THE APPROPRIATE COMMENT OF TWO ADMINISTRATION OF THE APPROPRIATE COMMENT OF TWO ADMINISTRATION OF THE APPROPRIATE COMMENT OF TWO ADMINISTRATION OF THE APPROPRIATE COMMENT OF TWO ADMINISTRATION OF THE APPROPRIATE COMMENT OF TWO ADMINISTRATION OF THE APPROPRIATE COMMENT OF TWO ADMINISTRATION OF THE APPROPRIATE COMMENT OF TWO ADMINISTRATION OF THE APPROPRIATE COMMENT OF TWO ADMINISTRATION OF T		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILD		CONSTRUCTION		E SURVEY IPLETED C
WESTPORT REHABILITATION AND NURSING CENTER    CALID   RUMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH COTTON SHOULD BE CROSS-REFERENCE) OT THE APPROPRIATE DEFICIENCY)    F 623   Continued From page 87			495227	B, WING			10	
FREERY TAG  Continued From page 87 Review of Resident #111's clinical record (including nurses' note dated 8/30/21 that documented Resident #11's clinical record (including nurses' note dated 8/30/21 that documented Resident #11 was fransferred to the hospital due to aggressive behaviors and a fall. Further review of the resident's clinical record (including nurses' notes) failed to reveal written notification of the transfer was provided to Resident #11's representative and the ombudsman, Review of a facility fax to the ombudsman Review of a facility fax to the ombudsman Review of a facility fax to the ombudsman review of the ist.  On 9/30/21 at 8:59 a.m., an interview was conducted with OSM (other staff member) #4, the social services director who began employment at the facility during the week of survey. OSM #4 stated written notification of resident transfers to the facility during the week of survey. OSM #4 stated written notification of resident transfers to resident representatives, OSM #4 stated the nurses are supposed to send a transfer notice form.  On 9/30/21 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated nurses are supposed to provide written notification of transfer to resident representatives via a transfer notice form.  Further review of Resident #111's clinical record failed to reveal a transfer notice form for the			D NURSING CENTER	•	7	300 FOREST AVE	<u>.</u>	
Review of Resident #111's clinical record revealed a nurse's note dated 8/30/21 that documented Resident #111 was transferred to the hospital due to aggressive behaviors and a fall. Further review of the resident's clinical record (including nurses' notes) failed to reveal written notification of the transfer was provided to Resident #111's representative and the ombudsman. Review of a facility fax to the ombudsman, dated 9/1/21, tilled, "Aug 2021 Discharges" falled to reveal documentation of Resident #111's transfer to the hospital on 8/30/21, on the list.  On 9/30/21 at 8:59 a.m., an interview was conducted with OSM (other staff member) #4, the social services director who began employment at the facility during the week of survey. OSM #4 stated written notification of resident transfers to the ombudsman is required monthly and is faxed. In regards to written notification of resident transfers to resident representatives, OSM #4 stated the nurses are supposed to send a transfer notice form.  On 9/30/21 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated nurses are supposed to provide written notification of transfer to resident representatives via a transfer notice form.  Further review of Resident #111's clinical record failed to reveal a transfer notice form.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
On 10/4/21 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.		Review of Resident # revealed a nurse's no documented Resident hospital due to aggres Further review of the (including nurses' not notification of the tran Resident #111's repre ombudsman, Review ombudsman, dated 9/ Discharges" failed to resident #111's transle #30/21, on the list.  On 9/30/21 at 8:59 a.r. conducted with OSM social services directed at the facility during the stated written notificat the ombudsman is reconstructed to written notificated the nurses are transfers to resident restated the nurses are transfer notice form.  On 9/30/21 at 10:37 a conducted with LPN (ILPN #7 stated nurses written notification of the presentatives via a terminal facility of the presentative via a terminal facility of the presentative via a terminal facility of the presentative via a terminal facility of the presentative via a terminal facility of the presentative via a terminal facility of the presentative via a terminal facility of the presentative via a terminal facility of the presentative via a terminal facility of the presentative via a terminal facility of the presentative via a terminal facility of the presentative via a terminal facility of the presentative via a terminal	111's clinical record te dated 8/30/21 that t #111 was transferred to the ssive behaviors and a fall. resident's clinical record as) failed to reveal written sfer was provided to sentative and the of a facility fax to the 11/21, titled, "Aug 2021 reveal documentation of fer to the hospital on  m., an interview was (other staff member) #4, the or who began employment e week of survey. OSM #4 ion of resident transfers to quired monthly and is faxed. otification of resident expresentatives, OSM #4 supposed to send a  .m., an interview was icensed practical nurse) #7. are supposed to provide ransfer to resident transfer notice form.  dent #111's clinical record afer notice form for the the hospital on 8/30/21.  .m., ASM (administrative administrator) and ASM #2		623			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	TIPLE CONSTR	UCTION		1	PLETED
		495227	B. WING				1	C /05/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER	<u> </u>	7300 FORE	ODRESS, CITY, STATEST AVE ND, VA 23226	FE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD E CED TO THE APPROPRI FICIENCY)	BE ATE	(X5) COMPLETION DATE
F 623	Continued From pag	e 88	F	623				
	Emergency" docume necessary to make a discharge to a hospit our facility will impler procedures:  a. Notify the resident b. Notify the receiving being made; c. Prepare the resided d. Prepare a transfer resident; e. Notify the representation member; f. Assist in obtaining g. Others as appropri	's Attending Physician; g facility that the transfer is ant for transfer; form to send with the antative (sponsor) or other transportation; and late or as necessary." The ent information regarding transfer to resident					15	
	No further information  1. B. Review of Residence and an urse's not documented the residence in the resident's clinical recified to reveal writte was provided to Resident's clinical recified to reveal writte was provided to Residence in the recipied in t	dent #111's clinical record of the dated 9/6/21 that dent was transferred to the Further review of the ord, including nurses' notes, in notification of the transfer dent #111's representative.		1.70				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				7.111	<u>0. 0938-0391</u>
STATEMENT (	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/O	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED C
		495227	B. WING			10	/05/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE DO FOREST AVE CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(XS) COMPLETION DATE
F 623	LPN #7 stated nurses written notification of representatives via a Further review of Res failed to reveal a tran #11's transfer to the failed to reveal a tran #11's transfer to the failed to reveal a tran #11's transfer to the failed to reveal a transfer to the failed to resident #72 was 3/9/15. Resident #72 was 3/9/15. Resident #72 were not limited to di osteoarthritis. Residin status minimum da assessment reference resident's cognitive simaking as moderated Review of Resident #73 a nurse's note dated resident was transfer right hip dislocation. resident's clinical recifailed to reveal writte was provided to Resident was transfer right hip dislocation.	s are supposed to provide transfer to resident transfer notice form.  sident #111's clinical record afer notice form for Resident nospital on 9/6/2021.  a.m., ASM (administrative administrator) and ASM #2 and were made aware of the administrator) and ASM #2 and were made aware of the new spresented prior to exit.  admitted to the facility on 2's diagnoses included but abetes, dementia and ent #72's significant change at a set assessment with an actual education of the distribution of the transfer including nurses' notes, an notification of the transfer ident #72's representative.  .m., an interview was 1 (other staff member) #4 (the document at the document at the document and the transfer ident #72's representative.  .m., an interview was 1 (other staff member) #4 (the document at transfer notice	·	623			
	On 9/30/21 at 10:37	a.m., an interview was					18

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY
						C
	ROVIDER OR SUPPLIER	2 NURSING CENTER	730	EET ADDRESS, CITY, STATE, ZIP COD 0 FOREST AVE CHMOND, VA 23226		0/05/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	1 SHOULD BE	(X5) COMPLETION DATE
F 623	conducted with LPN (LPN #7 stated nurses written notification of representatives via a Further review of Res falled to reveal a trans #72.  On 10/4/21 at 11:25 a staff member) #1 (the director of nursing above concern.  No further information 3. Resident #19 was a 4/10/17. Resident #1 were not limited to mufalls and high blood properties and high blood properties and high blood properties and high blood properties and high blood properties are sident's cognition as Review of Resident # the resident was trans 7/31/21 due to a fall. resident's clinical receptable to reveal written was provided to the official fax to the ombititled, "July 2021 Disc documentation of Restransfer on the list.  On 9/30/21 at 8:59 a.i.	licensed practical nurse) #7. If are supposed to provide transfer to resident transfer notice form.  Ident #72's clinical record after notice form for Resident  Im., ASM (administrative administrator) and ASM #2 g) were made aware of the awas presented prior to exit.  Indicate the facility on 19's diagnoses included but ascle weakness, repeated ressure. Resident #19's ta set assessment with an adate of 7/8/21, coded the asseverely impaired.  If so clinical record revealed afterned to the hospital on Further review of the red, including nurses' notes, anotification of the transfer mbudsman. Review of a adaman, dated 8/14/21 and harges" failed to reveal ident #19's 7/31/21,	F 623		St	PECEL MAN
	social services directo	other staff member) #4, the or who began employment be week of survey. OSM #4				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	8. WING				C 05/2021
	ROVIDER OR SUPPLIER			7	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 FOREST AVE RICHMOND, VA 23226	101	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION OATE
	stated written notifical the ombudsman is red the ombudsman is red on 10/4/21 at 11:25 a staff member) #1 (the (the director of nursing above concern.  No further information Comprehensive Asset CFR(s): 483.20(b)(2)(ii) With determines, or should there has been a sign resident's physical or purpose of this section means a major declineresident's status that vitself without further in implementing standarinterventions, that has one area of the reside requires interdisciplina care plan, or both.) This REQUIREMENT by:  Based on staff interviand facility document that the facility staff fa significant change MD assessment for one of sample, Resident #47.  The facility staff failed	ion of resident transfers to quired monthly and is faxed.  Im., ASM (administrative administrator) and ASM #2 g) were made aware of the was presented prior to exit. It is sement After Significant Chg gii)  In 14 days after the facility have determined, that lificant change in the mental condition. (For n., a "significant change" e or improvement in the will not normally resolve tervention by staff or by disease-related clinical an impact on more than not's health status, and any review or revision of the is not met as evidenced ew, clinical record review, review, it was determined field to complete a significant nent after dialysis services discontinued due to		623	1. Resident #47 remains in the center, upon notification from a significant change of condition assessment was completed dur duration of survey.  2. All residents reviewed from 09/01/2021 to ensure completion significant change of condition assessment was completed whappropriate change was observ 3. DON or designee will educate MDS coordinators on policy region completion of significant change condition assessment upon significant improvement or deciresident.	en of ed. e all arding e of	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE COMPI	
21101		A. BUILDII	NG			
	495227	B, WING_				) 05/2021
NAME OF PROVIDER OR SUPPLIER			ŞTR	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
WESTSON DOWN IN TATION AND AU	IDONO CENTED		730	0 FOREST AVE		
WESTPORT REHABILITATION AND NU	UKSING CENTER	1	RIC	CHMOND, VA 23226		
PREFIX (EACH DEFICIENCY MUS	MENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
The findings include:  Resident #47 was admitter 7/19/21 with the diagnose metabolic encephalopathy pulmonary disease, congetibrillation, somatoform distepression, insomnia, high stage renal disease, and crecent MDS (Minimum Datadmission/5-day assessment Reference Data resident was coded as bein ability to make daily lifer #47 was coded as requiring for transfers and limited at areas of activities of daily was coded as receiving diagram of the clinical recent and verbal, dialysis of was advised that resident due to better labs [laborated Daughter (name) and MD aware."  Further review of the clinical recent has a coded as receiving diagram of the clinical recent has a coded as receiving diagram of the clinical recent has a coded as receiving diagram of the clinical recent has a coded as receiving diagram of the clinical recent has a coded as receiving diagram of the clinical recent has a coded as receiving diagram of the clinical recent has a coded as receiving diagram of the clinical recent has a coded as receiving diagram of the clinical recent has a coded as receiving diagram of the clinical recent has a coded as receiving diagram of the clinical recent has a coded as coded as coded as coded as a coded as coded	ed to the facility on es of but not limited to by, chronic obstructive estive heart failure, atrial sorder, angina, gh blood pressure, end dysphagia. The most ata Set) was an nent with an ARD Date) of 7/22/21. The eing cognitively impaired e decisions. Resident ing extensive assistance assistance for all other living. Resident #47 lialysis services.  cord revealed a nurse's cumented, "Resident is called this AM, writer t does not need dialysis tory tests] results. 0 (medical doctor)  cat record revealed a e dated 9/17/21 that dialysis catheter will be 10/4/21, there was no change MDS (minimum ing completed.  an interview with RN #2	Fe	537	4. DON or designee will audit 10% of all residents to ascertain significant change of condition identified and completion of required MDS assessment was completed weekly times 4 week and monthly times 2 to ensure facility completes significant change of condition assessment in accordance with recommendations. Any identifier issues will be immediately corrected. Results will be report to Quality Assurance committee for analysis and revision x 3 months.  5. Date of compliance will be	ks ets ed	·/[4/2]

	OF DEFICIENCIES CORRECTION	CALLOS (VA) LICADELADOR LEGISTOCK		(X3) DATE SURVEY COMPLETED			
		7.00	A, BUILD	ii4G			,
		495227	B. WING			10/0	05/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTPOR	RT REHABILITATION AN	NURSING CENTER		ı	7300 FOREST AVE		
712017-01					RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 637	Continued From page		F	637	7		
	"If a significant chang change MDS is comp	e is identified, a significant					
		significant change and an					
	assessment should ha	ave been done." When					
		ollowed to complete the			68		
	MDS, she stated, "Th						
	Assessment Instrume	nt) Manual.				:	
	According to the RAI Version 1.17.1, Page	Manual, October 2019, 2-22 documented:					
ļ	"A "significant change	" is a major decline or					
	improvement in a resi					:	
	1. Will not normally re		1				
		r by implementing standard all interventions, the decline					
	is not considered "seli						
	2. Impacts more than	one area of the resident's					
	health status; and					98	
	3. Requires interdiscip revision of the care pl						275
	revision of the care pr	di I.					
	Page 2-23 documents	ed:					
	occurred as indicated resident's current stat	ition that a significant ement or decline) in a om his/ner baseline has by comparison of the					
	Quarterly assessment						
	Staff Member) the Add Director of Nursing, w	formation was provided by					

CENTER	S FOR MEDICARE &	1		CONCENTRATION	(X3) DATE SURVEY
	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	COMPLETED
AND FLAN UP	CONCENTION		N. BUILDING _		С
		495227	B, WING		10/05/2021
NAME OF B	ROVIDER OR SUPPLIER	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	s.	TREET ADDRESS, CITY, STATE, ZIP CODE	
			7:	300 FOREST AVE	
WESTPOR	RT REHABILITATION AN	D NURSING CENTER	R	ICHMOND, VA 23226	
	TP VQAMADV ST	ATEMENT OF DEFICIENCIES	I ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DL
- 6			+ 3		
E 645	Continued From page	o 94	F 645		
	PASARR Screening		F 645	1. Resident #160 no longer resident	tes
F 645 SS=D				in facility. Resident #22 remains	in
33-0	CFT(3). 400.20(K)(1)	-(0)	1	center. Facility is working with	745
	§483,20(k) Preadmis	sion Screening for		referral source to locate PASAA	R.
	individuals with a me	ntal disorder and individuals		2. Review all current residents to	0
	with intellectual disab			ensure completion of PASAAR	and
				remains on medical record.	
	§483.20(k)(1) A nurs	ing facility must not admit, on	1	3. DON or designee will provide	
	or after January 1, 19	989, any new residents with:		facility social worker and admiss	sions
	(i) Mental disorder as	defined in paragraph (k)(3)		on policy for receiving PASAAR	S as
	(i) of this section, unl	ess the State mental health		appropriate.	000
	authority has determ	Ined, pased on all		4. DON or designee will audit 10	J%
	independent physica	I and mental evaluation on or entity other than the		of all new admissions to ensure	.
	State mental health a	authority, prior to admission,		PASAAR included on in medica	nco's
	(A) That because of	the physical and mental		records for all appropriate insta	thiv
	condition of the indiv	idual, the individual requires		weekly times 4 weeks and mon times 2 to ensure that the facilit	u ny
	the level of services	provided by a nursing facility;		maintains requirements for	<sup>y</sup>
	and			preadmission screening. Any	
	(B) If the individual re	equires such level of		identified issues will be immedia	ately
	services, whether the	e individual requires		corrected. Results will be repor	ted to
	specialized services;	or		Quality Assurance committee for	or
	(ii) Intellectual disabi	lity, as defined in paragraph		analysis and revision x 3 month	ıs.
[	(k)(3)(ii) of this section	on, unless the State		5. Date of compliance will be	
	intellectual disability	or developmental disability			1 .
	authority has determ	ined prior to admission- i the physical and mental			1/19/2
	(A) That, because of	ridual, the individual requires			1,1,1,1
ļ	the level of services	provided by a nursing facility;			
	and	provided by a new and colonia,			1
		equires such level of			
ì	services, whether th	e individual requires	6		
	specialized services	for intellectual disability.			
		otions. For purposes of this			
	section-				ļ
	(i)The preadmission	screening program under			-
	paragraph(k)(1) of the	his section need not provide			

PRINTED: 10/19/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B, WING		1	05/2021
	PROVIDER OR SUPPLIER	O NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			(XS) COMPLETION DATE
F 645	for determinations in to a nursing facility of being admitted to the transferred for care in (ii) The State may cho preadmission screenir paragraph (k)(1) of this to a nursing facility of (A) Who is admitted to hospital after receiving hospital, (B) Who requires nurs condition for which the the hospital, and (C) Whose attending performed before admission to the likely to require less facility services.  §483.20(k)(3) Definition section— (i) An individual is considered defined in 483 (ii) An individual is consintellectual disability as or is a person with a redescribed in 435.1010 This REQUIREMENT by:  Based on staff interview and facility document in the facility staff failed to screening and resident completed and or completed and or completed and or completed and or completed in the staff failed to screening and resident completed and or comp	the case of the readmission an individual who, after nursing facility, was a hospital.  to se not to apply the ag program under se section to the admission an individual-to the facility directly from a gracute inpatient care at the individual received care in the individual received care in the individual than 30 days of nursing than 30 days of nursing m. For purposes of this sidered to have a mental al has a serious mental al has a serious mental al has a serious mental al has a serious mental al has a serious mental al has a serious mental al has a serious mental al has a serious mental al has a serious mental al has a serious mental al has a serious mental al has a serious mental al has a serious mental al has an al defined in §483.102(b)(3) allated condition as	F	645		

<u> </u>	O TOR MEDIOAINE &	MEDICAID SEIVAIGES							
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	157		INSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495227	B, WING				ı	05/2021	
WANE 05.5	00111050 00 011001150	400221			EET ADDRESS, CITY, STATE, ZIP C	2006	1 101	0012021	
NAME OF P	ROVIDER OR SUPPLIER			l		OUL			
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		7300	FOREST AVE			:	
				RICH	IMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD B THE APPROPRI		(X5) COMPLETION DATE	
F 645	Continued From page 96  1. The facility failed to ensure a PASARR was completed upon admission for Resident #160.		F	645					
	The facility staff fai Resident #22's level I	iled to thoroughly complete PASRR (Preadmission ent Review) and failed to							
	9/9/21. Resident #16i were not limited to: ei stage of renal failure-i excrete wastes and fu of electrolyte balance) (mental disorder charadistortions of reality, we contacts and disturbai perception and emotion chronic obstructive pur (chronic and non-reversedent #160's most data set) assessment, with an assessment recoded the resident as					<b>9</b> 7			
	indicating the resident MDS Section G- Fun	was cognitively intact.  tional Status: coded the  extensive assistance in bed lking, locomotion, dressing, giene and bathing;							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		l ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00/4/20/10/1		A, BUILDI	ING		(	:
ļ		495227	B. WING			1	05/2021
NAME OF P	ROVIDER OR SUPPLIER			Π	STREET ADDRESS, CITY, STATE, ZIP CODE		
ĺ					7300 FOREST AVE		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER			RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 645	An interview was completed with edirector of nursing a PASARR completed stated, "No, we don't an interview was completed with the director of social service purpose of the PASAR PASARR is used to disability so we can di	ducted on 9/29/21 at 3:40 sistrative staff member) #2, y. When asked if there was d for Resident #160, ASM #2 have one."  ducted on 10/05/21 at 9:23 staff member) #4, the sices. When asked the RR, OSM #4 stated, "The etermine mental illness or etermine if we can meet eds at this facility." When sible to obtain the PASARR, ally we get a PASARR prior illity or at the time of social services would do SM #4 stated, "I started as not here when this 60) was admitted on 9/9/21. Sures that level II screening sorted."  It is in Criteria", dated part, "All new admissions a screened for mental ectual disabilities (ID) or per the Medicaid ming and Resident Review sty conducts a Level I will potential admissions, purce, to determine if the criteria for MD, ID or RD, If icates that the individual for a MD, ID or RD, he or		645			
	representative for the	Level II (evaluation and	<u> </u>				<u> </u>

PRINTED: 10/19/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO		(X3) DATE SURVEY COMPLETED			
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	<del></del>		С		
		495227	B. WING				ļ	05/2021	
	ROVIDER OR SUPPLIER	D NURSING CENTER	_	7300	ET ADDRESS, CITY, STATE FOREST AVE IMOND, VA 23226	, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST 8E PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE	
F 645	were made aware of the No further information of the No further information of the Northern Information of the Northern Special Reader, Chapman, page 498. (2) Barron's Dictionary Non-Medical Reader, Chapman, page 518. (3) Barron's Dictionary Non-Medical Reader, Chapman, page 120. 2. The facility staff fail Resident #22's level I	M, ASM #1, the M #2, the director of nursing the above findings.  I was provided prior to exit.  y of Medical Terms for the 5th edition, Rothenberg and y of Medical Terms for the 5th edition, Rothenberg and y of Medical Terms for the 5th edition, Rothenberg and y of Medical Terms for the 5th edition, Rothenberg and ed to thoroughly complete PASRR (Preadmission ent Review) and failed to	F	645					
	were not limited to mu and major depressive quarterly minimum da	's diagnoses included but ultiple sclerosis (1), seizures disorder. Resident #22's ta set assessment with an e date of 9/24/21, coded the							
	a DMAS (Department Services) - 95 form titl MENTAL ILLNESS, M RETARDATION/INTE	LLECTUAL DISABILITY, ITIONS" and dated 7/5/21.							

Facility (D: VA0270

		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
I			495227	B. WING				C 05/2021
ŀ	NAME OF P	ROVIDER OR SUPPLIER	4,022.1			STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	03/2021
	WESTPOR	RT REHABILITATION AND	NURSING CENTER	23		7300 FOREST AVE RICHMOND, VA 23226		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(XS) COMPLETION DATE	
		beside "Yes" and "No. checked. The form fursafe and appropriate preed all services and medical/nursing/custocheck box was docum "No." Neither option with the form further documented, "ANDIVIDUAL HAVE A MANIFESTED BEFORCHECK box was docum "No." Neither option with the following similar to that of IDD preadment of services spersons? Yes. b. Has before age 22? Yes. continue indefinitely? Yes. (a check mark beside Condition (#3 or #4 is condition (#3 or #4 is condition (#3 or #4 is continue instructions for continue instructions for continue instructions for continue (#3 or #4 is condition (#3 or #4 is condition (#3 or #4 is continue instructions for continue inst	URSING FACILITY check box was documented "Neither option was rther documented, "Can a clan of care be developed to supports including dial care needs?" A blank ented beside "Yes" and vas checked.  mented, "3. DOES THE DIAGNOSIS OF BILITY (ID) WHICH WAS REAGE 18?" A blank ented beside "Yes" and vas checked. The form 1. DOES THE INDIVIDUAL DNDITION? Yes. a. Is the to any other condition (e.g. ther than MI (mental besty related to IDD ental disability) because ult in impairment of general or adaptive behavior ersons and requires similar to those of these the condition manifested to Is the condition likely to fes. d. Has the condition limitations in 3 or more of major life activity; self-care of language, learning, and capacity for s. 5. RECOMMENDATION lee) IDD or Related	F	645			

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. 601C01	טרון		1 ,	С
	PROVIDER OR SUPPLIER  STREET PRY REHABILITATION AND NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Care: Indicate whether the individual meets nursing facility level of care criteria. For reference, level of care criteria can be found in the Medicaid Long-Term Services and Supports Manual Chapter IV found on the Virginia Medicaid portal. If 'yes' is checked, complete the screening, If 'no', is checked, the individual does NOT meet nursing facility level of care criteria, do not complete the Level I screening and do not refer for a Level II evaluation 3. Determination of Intellectual Disability ID: Check 'yes' if the individual has a level of intellectual disability (mild, moderate, severe, or profound) described in the Classification in Mental Retardation: Chapter 3. American Association on Mental Deficiency (AAMD), 1983 that was manifested before age 18. Please note this reference is specifically cited in the Code of Federal Regulations but the AAMD is now known as the American Association on intellectual and Developmental Disabilities (AAIDD) and the term Mental Retardation is no longer standardly used and has been replaced with Intellectual Disability. 4. Determination of Related Conditions: Check 'yes' for answer for 4, only if each item in 4, a-d is checked 'yes'. If any answer to a-d is 'no', then			1	05/2021		
NAME OF D	DOMINED OR STIPPI IED	77022	1	F	STREET ADDRESS, CITY, STATE, ZIP CODE	101	0072021
MANIE OF P	ROVIDER OR SUPPLIER				7300 FOREST AVE		
WESTPOR	RT REHABILITATION AND	NURSING CENTER			RICHMOND, VA 23226		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION DATE
F 645	Continued From page	100	F	64	5		
	Care: Indicate whether	r the individual meets			1		
	nursing facility level of	f care criteria. For	İ		1	3	
						3	
	NAME OF PROVIDER OR SUPPLIER  WESTPORT REHABILITATION AND NURSING CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION)  F 645  Continued From page 100  Care: Indicate whether the individual meets nursing facility level of care criteria. For reference, level of care criteria can be found in the Medicaid Long-Term Services and Supports Manual Chapter IV found on the Virginia Medicaid portal.  If 'yes' is checked, complete the screening. If 'no', is checked, the individual does NOT meet nursing facility level of care criteria, do not complete the Level I screening and do not refer for a Level If evaluation  3. Determination of Intellectual Disability ID: Check 'yes' if the individual has a level of intellectual disability (mild, moderate, severe, or profound) described in the Classification in Mental Retardation: Chapter 3. American Association on Mental Deficiency (AAMD), 1983 that was manifested before age 18. Please note this reference is specifically cited in the Code of Federal Regulations but the AAMD is now known as the American Association on Intellectual and Developmental Disabilities (AAIDD) and the term Mental Retardation is no longer standardly used and has been replaced with Intellectual Disability.  4. Determination of Related Conditions: Check 'yes' for answer for 4, only if each item in 4, a-d is						
	IDENTIFICATION NUMBER:  495227  PVIDER OR SUPPLIER  REHABILITATION AND NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 100  Care: Indicate whether the individual meets sursing facility level of care criteria. For eference, level of care criteria can be found in the Medicaid Long-Term Services and Supports Manual Chapter IV found on the Virginia Medicaid tortal.  Fives' is checked, complete the screening.  Fino', is checked, the individual does NOT meet tursing facility level of care criteria, do not complete the Level I screening and do not refer or a Level II evaluation  Determination of Intellectual Disability ID: Check 'yes' if the individual has a level of the tellectual disability (mild, moderate, severe, or rofound) described in the Classification in dental Retardation: Chapter 3. American association on Mental Deficiency (AAMD), 1983 that was manifested before age 18. Please note his reference is specifically cited in the Code of dederal Regulations but the AAMD is now known as the American Association on Intellectual and developmental Disabilities (AAIDD) and the term dental Retardation is no longer standardly used and has been replaced with Intellectual Disability.  Determination of Related Conditions: Check 'yes'. If any answer to a-d is 'no', then no' is checked for the overall question and do not effer for Level II evaluation for related conditions.  Check 'yes' if the condition is attributable to any their condition, other than MI, found to be closely elated to intellectual disability because this condition may result in impairment of general attellectual functioning or adaptive behavior imilar to that of persons living with ID and acquires treatment or services similar to those for						
	•						
					1		
						9	
	WESTPORT REHABILITATION AND NURSING CENTER  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 645  Continued From page 100  Care: Indicate whether the individual meets nursing facility level of care criteria. For reference, level of care criteria can be found in the Medicaid Long-Term Services and Supports Manual Chapter IV found on the Virginia Medicaid portal.  If 'yes' is checked, complete the screening. If 'no', is checked, the individual does NOT meet nursing facility level of care criteria, do not complete the Level I screening and do not refer for a Level II evaluation  3. Determination of Intellectual Disability ID: Check 'yes' if the individual has a level of intellectual disability (mild, moderate, severe, or profound) described in the Classification in Mental Retardation: Chapter 3. American Association on Mental Deficiency (AAMD), 1983 that was manifested before age 18. Please note this reference is specifically cited in the Code of Federal Regulations but the AAMD is now known as the American Association on Intellectual and Developmental Disabilities (AAIDD) and the term Mental Retardation is no longer standardly used and has been replaced with Intellectual Disability.  4. Determination of Related Conditions: Check 'yes' for answer for 4, only if each item in 4, a-d is checked 'yes'. If any answer to a-d is 'no', then 'no' is checked for the overall question and do not refer for Level II evaluation for related conditions.  a. Check 'yes' if the condition is attributable to any				1	Į.	
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		-			1	2.1	
	Determination of Intellectual Disability ID:     Check 'yes' if the individual has a level of						
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i					i e		
	Association on Mental	Deficiency (AAMD), 1983					
	that was manifested b	efore age 18, Please note					
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	requires treatment or s	services similar to those for					
	persons living with ID.						
		ondition has manifested					
	before age 22		1		1	1.00	V

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A, BUILD			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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L		495227	B, WING			10/	05/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				7	300 FOREST AVE			
WESTPOR	RT REHABILITATION AN	D NURSING CENTER	10					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
F 645	Continued From page	101	F	645				
;	c. Cheek 'yes' if the co	ondition is likely to continue						
	d. Check 'yes' if the co	ondition has resulted in						
	substantial limitations	in three (3) or more of the						
	following areas of maj	or life activity: self-care,						
	understanding, use of	language, learning,						
	mobility, self-direction	, and capacity for		- 3				
	Independent living. Ci	rcle the applicable areas."			•			
	The Pre-Admission Se	creening (PAS) Virginia						
}		Frequently Asked Questions						
	website documented,	•						
	"Do I need to complet	e this form for a member						
	I'm referring for Level	I services?						
	Based upon the outco	me of the Level I screening						
	for MI/ID/RC, the com	pletion of the DMAS-95						
	MI/MR Supplement wi	ill be determined. If the						
	member is identified h	as having a mental illness,	2					
	intellectual disability, of	or related condition during		- 1				
	the Level I screening	process, a referral for the		- 3				
	completion of the Leve	el II screening must be		9	X*		1.73	
	made. "This information website:	on was obtained from the	9					
		niamedicaid.dmas.virginia.g						
		ontent?impersonate=true&i					,	
		675-BD19-9233DEB7E4B0						
	}			- 1				
	%vsld={09D26C54-48	95-4389-A19E-2ED4DD395		- 1				
	861}							
į į	&objectType=docume	nt&objectStoreName=VAP					2	
	RODOS1	•						
	The employee who co	mpleted Resident #22's						
		R) was no longer employed	2					
	at the facility.							
	On 9/30/21 at 8:59 a.r	n., an interview was						
		other staff member) #4, the						
	social services directo							

PRINTED: 10/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED С

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING 495227 B. WING 10/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE **WESTPORT REHABILITATION AND NURSING CENTER** RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) (D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC (DENTIFYING INFORMATION) TAG DEFICIENCY) F 645 Continued From page 102 F 645 completes a PASRR upon admission for every resident who is admitted to the facility. Resident #22's DMAS-95 form was reviewed with QSM #4. OSM #4 stated "yes" or "no" should have been checked for question #1. In regards to question #3, OSM #4 stated, "it's never okay to leave anything blank. If I would have done it, I would not have left anything blank. A lot of people don't get training on PASRR." In regards to the recommendation in question #5, OSM #4 stated Resident #22 should have been referred to the company that completes level II PASRRs. OSM #4 stated it sometimes takes a while for the company to respond and she would check to see if a referral for Resident #22 had been made. On 9/30/21 at 12:52 p.m., OSM #4 stated she was unable to locate any paperwork to evidence Resident #22 had been referred for a level II PASRR. On 10/4/21 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Admission Criteria" documented, "9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD.

b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or

MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD	TIPLE CO	(X3) DATE SURVEY COMPLETED				
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E OF PROVIDER OR SUPPLIER	453221	2.11,110	eme.	CT LODGEGG GEDY G		10/	05/2021	
STPORT REHABILITATION AN	D NURSING CENTER		7300	ET AODRESS, CITY, S FOREST AVE IMOND, VA 23226	IAIE, ZIP CODE			
FIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CCTIVE ACTION SHOULD B INCED TO THE APPROPRI DEFICIENCY)			
determination) screen (1) The admitting nurs services department to as having a possible (2) The social worker referrals to the appropriate of the services department to as having a possible (2) The social worker referrals to the appropriate of the PASARR repressindividual has a physic what specialized or resident appropriate. d. The State PASARR copy of the report to the enterdisciplinary the facility is capable of services of the potential in the evaluation. f. Once a decision is in representative, the potent representative are No further information Reference:  (1) "Multiple sclerosis disease that affects you damages the myelin is surrounds and protect information was obtain https://vsearch.nlm.nihmeta?v%3Aproject=m medlineplus-bundle&q	state PASARR Level II (evaluation and aing process. se notifies the social when a resident is identified (or evident) MD, ID or RD. is responsible for making priate state-designated of the Level II evaluation, the centative determines if the cal or mental condition, habilitative services he or mer placement in the facility of representative provides a me facility. It represents the needs and all resident that are outlined made, the State PASARR tential resident and his or notified."  (MS) is a nervous system our brain and spinal cord. It theath, the material that is your nerve cells." This	F	645			Si de la constante de la const		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WNG				C 05/2021
	ROVIDER OR SUPPLIER	NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		300 FOREST AVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656 SS=E	CFR(s): 483.21(b)(1)  §483.21(b) Comprehe §483.21(b)(1) The fact implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that inco objectives and timefra medical, nursing, and needs that are identific assessment. The com describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that v under §483.24, §483.2 provided due to the re under §483.10, includ treatment under §483 (iii) Any specialized se rehabilitative services provide as a result of recommendations. If a findings of the PASAR rationale in the reside (iv)In consultation with resident's representat (A) The resident's goa desired outcomes. (B) The resident's pre- future discharge. Faci whether the resident's community was asses local contact agencies entities, for this purpo-	ensive person-centered ident, consistent with the hat §483.10(c)(2) and cludes measurable imes to meet a resident's mental and psychosocial ed in the comprehensive inprehensive care plan must are to be furnished to attain int's highest practicable psychosocial well-being as ea, §483.25 or §483.40; and would otherwise be required e25 or §483.40 but are not isident's exercise of rights ing the right to refuse a facility disagrees with the ear, it must indicate its int's medical record. In the resident and the ive(s)-list for admission and ference and potential for lities must document a desire to return to the ised and any referrals to and/or other appropriate	F		1. Resident #160 no longer resides in center. Resident #22, #45, #82, #153 #145 and #165 care plans have been updated to represent comprehensive plan of care.  2. Ensure all current residents residing center reviewed to ensure comprehensive care plan is establish and implemented.  3. DON or designee will educate all facility nursing staff to ensure understanding and requirements for implementation of comprehensive caplans.  4. DON or designee will audit 10% or residents to ascertain development a implementation of comprehensive caplan weekly times 4 weeks and montitimes 2 to ensure facility maintains the development/Implementation of comprehensive care plans. Any identissues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis ar revision x 3 months.  5 Date of compliance will be	ang in med fall and are they he	1/19/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495227	B, WING		<u></u>		05/2021
	PROVIDER OR SUPPLIER	D NURSING CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE 00 FOREST AVE CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	105	F	656			
	plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on staff intervifacility document revireview, it was determidevelop and/or impleie care plan for seven of sample, Resident #'s #145, #165 and #22. The facility staff failed comprehensive care Resident #160 and Redevelop a comprehen the physician prescrib spirometer for Reside implement compreheie and monitoring weigh Resident #153; failed comprehensive care pas ordered to Resider #22's pressure ulcers comprehensive care pordered by the physician The findings include:  1. Resident #160 was 9/9/21. Resident #16 was 9/9/21. Resident #16 was 9/9/21. Resident #16 was 9/9/21 of kidneys to excrete was maintenance of electrischizophrenia (mental	in accordance with the in paragraph (c) of this is not met as evidenced lew, resident interview, and clinical record ined the facility staff failed to ment the comprehensive 84 residents in the survey #160, #45, #82, #153, to develop a plan to address dialysis for esident #45; failed to sive care plan to address and use of an incentive int #165, and failed to insive care plan for obtaining its for Resident #82 and to implement the plan to provide treatments int #153's and Resident and failed to implement the plan to provide oxygen as ian to Resident #145.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B, WING			C 10/05/2021
	ROVIDER OR SUPPLIER RT REHABILITATION AN	D NURSING CENTER	<b>1</b>	STREET ADDRESS, CITY, STATE 7300 FOREST AVE RICHMOND, VA 23226	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD B ED TO THE APPROPRI ICIENCY)	E COMPLETION
THE SECTION AND	contacts and disturba perception and emotic chronic obstructive put (chronic and non-reversal contacts and disturbation and perception and emotic chronic obstructive put (chronic and non-reversal chronic and non-reversal chronic and non-reversal chronic and non-reversal chronic and session and	nces of thought, language, conal response) (2) and almonary disease 'COPD' ersible lung disease) (3).  Trecent MDS (minimum, a quarterly assessment, eference date of 2/6/20, scoring 13 out of 15 on the for mental status) score, it was cognitively intact. Itional Status: coded uiring extensive assistance ers, walking, locomotion, ersonal hygiene and with eating. MDS- Section coded the resident as for both bowel and bladder. Itial Treatments and esident #160 as receiving exident #160 as receiving and Time: M-W-F Pick up to 10:55."  Inducted on 9/30/21 at 10:00 dispractical nurse) #5, of the comprehensive care To identify the needs of the see." When asked if	F	656		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL			(X3) DATE SURVEY COMPLETED		
	,		A, BUILD				(	,
		495227	B. WING				10/	05/2021
	ROVIDER OR SUPPLIER	NURSING CENTER		7300	EET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE HMOND, VA 23226	i		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)				(X5) COMPLETION DATE
F 656	the dialysis site for signal interview was come PM with LPN #2, the expurpose of the compristated, "It is for every and to know their need to do for the resident: should be on the come #2 stated, "Yes, it should be on the come #2 stated, "Yes, it should be on the come #2 stated, "Yes, it should be on the come #2 stated, "Yes, it should be on the come #2 stated, "Yes, it should be on the come property #1, the admitistion of nursing we findings.  A review of the facility Planning-Interdisciplic documented in part, "Ithe resident's compredeveloped by the care team including register assistants responsible A review of the facility Disease, Care of a Re 9/10, documented in promprehensive care preeds related to ESR.  No further information References:  (1) Barron's Dictionary Non-Medical Reader, Chapman, page 498.  (2) Barron's Dictionary Dictionary Page 498.	ducted on 10/4/21 at 12:20 unit manager, regarding the ehensive care plan. LPN #2 one to be on the same page ds. It is everything we need "When asked if dialysis prehensive care plan, LPN utd be on the care plan."  A, ASM (administrative staff inistrator and ASM #2, the re made aware of the above "s "Care hary Team" policy, The care plan is based on hensive assessment and is a planning/interdisciplinary ared nurse and nursing a for the resident's care."  's "End-Stage Renal esident with" policy dated bart, "The resident's plan will reflect the resident's	F	656				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILD			CONSTRUCTION	COMPLETED		
		495227	B. WING			1	C /05/2021	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>			TREET ADORESS, CITY, STATE, ZIP CODE			
WESTPOF	RT REHABILITATION AND	NURSING CENTER		7: R				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Non-Medical Reader, Chapman, page 120.  2. The facility staff fai comprehensive care president #45.  Resident #45 was addiagnoses that include stage 4 kidney diseas Resident #45's most reset), a quarterly asses (assessment reference Resident #45 as scori assessment for menta of 0 - 15, 3- being sevically decisions. Sectivas receiving dialysis with facility.  The comprehensive calcalled to evidence a calcalled t	y of Medical Terms for the 5th edition, Rothenberg and iled to develop a clan to address dialysis for mitted to the facility with ed but were not timited to e (1) and heart failure (2), ecent MDS (minimum data esment with an ARD e date) of 7/20/2021, coded ing a 3 on the staff al status (BIMS) of a score erely impaired for making on O coded Resident #45 while a resident at the  are plan for Resident #45 are plan related to or ervices.  for Resident #45 Hemodialysis (3) Diagnosis: al disease) Dialysis Days -Sat Pick up time: varies lysis Center; [Name and esis center] Transport and phone number of e: 5/7/2021."  r Resident #45 documented 3 (1:13 p.m.) Acute on ley Disease- now on HD	F	656				
	On 10/4/2021 at 11:36	a.m., an interview was	10				1	

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
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		495227	B. WING_			10/05/2021
	PROVIDER OR SUPPLIER RT REHABILITATION AN	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APT DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	conducted with LPN (LPN #8 stated that cat LPN #8 stated that the responsible for the bat MDS (minimum data at comprehensive care gupdate. LPN #8 state should have a care ploth of the care plant and that they reviewed assessment summary assessment to direct liplant was a care plan addrives manager would it.  On 9/30/2021 at 1:10 conducted with LPN #10 stated that the care plan and the care plan notified the care plan notified the care plan notified the care plan stated that RN #10 stated that Rdialysis and should hat their record. LPN #10 review the care plan to plan to address dialysis on 10/5/2021 at approximation to 10/5/2021 at approximation 10/5/2021 at ap	licensed practical nurse) #8, are plans were a team effort. It is nurse manager was seline care plan and the set) nurse completed the plan which the nurses could at that all dialysis residents an addressing dialysis.  p.m., an interview was egistered nurse) #2, MDS arse. RN #2 stated that the an was to direct the care of RN #2 stated that the care of the interdisciplinary team of the CAAS (care area of the care plans they put into that dialysis residents should essing their dialysis and the be responsible for creating p.m., an interview was 10, the unit nurse manager. The care plan was a resident was a resident #45 received we a dialysis care plan on stated that they would see if there was a care is.	F 6	56		
		tor of nursing for the facility				

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	495227	B, WING			C 10/05/2021	
ME OF PROVIDER OR SUPPLIER		li	STREET ADDRESS, CITY, STATE, ZIP COL	)E	10/1	03/2021
ESTPORT REHABILITATION A	ND NURSING CENTER		7300 FOREST AVE RICHMOND, VA 23226			
4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD I  AG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPR  DEFICIENCY)		N SHOULD BI APPROPRIA		(X5) COMPLETION DATE		
the facility used Lipp standard of practice.  The facility policy "C Team" documented based on the resider assessment and is deplanning/Interdiscipl.  According to Fundar Williams and Wilkins documented, "A writt communication tool members that helps careThe nursing califormation about the and goals. It contain achieving the goals of and is used to direct.  On 10/4/2021 at app (administrative staff in administrator and AS were made aware of No further information.  References:  1. Kidney failure (ES your blood by removing and wastes. They als your bones strong and the kidneys are dama properly. Harmful was body. Your blood premay retain excess flut.	are Planning- Interdisciplinary in part, "The care plan is nt's comprehensive eveloped by a Care inary Team"  Inentals of Nursing Lippincott 2007 pages 65-77 en care plan serves as a among health care team ensure continuity of are plan is a vital source of a patient's problems, needs, is detailed instructions for established for the patient care"  Toximately 4:30 p.m., ASM member) #1, the M #2, the director of nursing the concern.  The was provided prior to exit.  RD): Healthy kidneys cleaning excess fluid, minerals, o make hormones that keep d your blood healthy. But if	F	656	24		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILD			С	
		495227	B. WING		<del></del>	10/	05/2021
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIS DEFICIENCY)		(XS) COMPLETION DATE
1	information was obtain https://medlineplus.go 2. Heart failure: A corno longer able to pum rest of the body efficie to occur throughout the was obtained from the https://medlineplus.go 3. Hemodialysis: Dial failure. It removes wayour kidneys can no lot Hemodialysis (and other some of the job of the working well. This inforthe website: https://medlineplus.go 00707.htm. 3. The facility staff fail #82's comprehensive monitoring weights. Resident #82 was addiagnoses that include hemiplegia (1) and cer Resident #82's most reset), an annual assess (assessment reference Resident #82 as scoring assessment for mental of 0 - 15, 2- being sevolaily decisions. Section	ned from the website:  hy/kidneyfailure.html  dition in which the heart is ap oxygen-rich blood to the ently. This causes symptoms the body. This information website:  hy/ency/article/000158.htm.  lysis treats end-stage kidney age from your blood when longer do their job.  her types of dialysis) does kidneys when they stop formation was obtained from hy/ency/patientinstructions/0  led to implement Resident care plan for obtaining and hitted to the facility with hid but were not limited to rebral infarction (2).  lecent MDS (minimum data sment with an ARD and at the appeal of a score erely impaired for making on K coded Resident #82 as and a therapeutic diet	F.	656	Derivatively.		
	The comprehensive ca	are plan for Resident #82					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NO PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) PROVIDER/SUPPLIER/CLIA		(X2) MULT A, BUILDI		ONSTRUCTION		COMPLETED		
		495227	B. WING				C 10/05/2021		
	ROVIDER OR SUPPLIER	D NURSING CENTER	· <u>/</u> -	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)			(X6) COMPLETION DATE		
F 656	documented in part, "risk r/t (related to) por need for enteral feed: 11/06/2019, Revision "Interventions/Tasks" "Notify physician and significant weight chat 11/06/2019" and "We Initiated: 11/06/2019. documented, "Need to complications of feed aspiration potential, seed (due to) CVA (stroke) supplemental nutritio regular po (by mouth head of bed in flat pot 11/21/2020. Revision "Interventions/Tasks" "Monitor weights and Date Initiated: 09/10/Resident #82 documented to AFib (3)C Revision on: 06/10/20" Interventions/Tasks" "Obtain weights as in significant changes, seed the most on 5/8/2021 with Respounds.  The physician order failed to evidence and for Resident #82.  The clinical record for the control of the control of the control of the clinical record for Resident #82.	At potential for nutritional or po (by mouth) intake and sDate Initiated: on: 04/15/2021." Under it documented in part, responsible party of inges, Date Initiated: lights as ordered, Date" The care plan further or feeding tube/potential for ing tube use related to wallowing impairment d/t. Feeding tube used for and for flushes. Tolerating diet Resident will put her sittion, Date Initiated: on 11/21/2020." Under it documented in part, report significant changes, 2020" The care plan for ented, "Cardiac disease that initiated: 11/07/2019, 020." Under it documented in part, dicated and report Date Initiated: 02/20/2020"	F	656			42 42 5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A, BUILDI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A, COILO	,,,	· <del></del>	c	
		495227	8. WING			10/05/20	21
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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F 656	Continued From page	113	F	656	6		
		ition Evaluation" dated					į
		It #82 documented in part, le from May 2021Recc					
,	(recommendations):					9	
	ordered"	.vs.am moigins as					
	On 9/30/2021 at 1:10	p.m., an interview was	10				
		icensed practical nurse)	7)				
	#10, the unit nurse ma	nager. LPN #10 stated					
		a communication tool for					
	the staff to communica						
		ated that the care plan					
i		tified nursing assistants) of					
	any special needs of the	ne resident. LPN #10 vere weighed monthly and					
		mented in the computer.				2	
	•	a resident refused to be				1	
	weighed they notified t						
	•	N #10 stated that Resident			39		334
	#82 received tube feed	fing and was important to			. 1		
	monitor for weight chair	nges. LPN #10 stated that					
		there were no weights for					
	Resident #82 documer	nted after May 2021.					
	On 10/4/2021 at 10:37	a.m., an interview was					
		other staff member) #8,					
		ed that they tracked all the					
		and monitored the weights					
r	for any significant gain						
		32 received tube feeding					
		hes through their feeding outh. OSM #8 reviewed	0				
- 1	•	record and stated that the					
		ff after May of 2021. OSM					
	#8 stated that accordin	-					
	weight in May, Resider					8	
		eds but they would prefer					
		of weights more recently					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	50		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A, BUILD	ING	**************************************	١,	c	
		495227	B. WING				05/2021	
NAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE			
WESTPOR	RT REHABILITATION AND	NURSING CENTER			7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE	
F 656	Continued From page obtained then that of I		F	656	6			
		e the staff to document any						
	conducted with LPN # weights were monitore month unless they we LPN #8 stated that res feeding required monit being more high risk for							
	stated that the care pla	e progress notes, LPN #8 an was not being followed if g monitored as documented						
	10/17/2018 documents are weighed a minimul of each month with mo	r deemed necessary. 5. and documented in the		-				
	(administrative staff me	#2, the director of nursing						
	No further information	was provided prior to exit.						
	References:							
	Paraplegia, Quadripleg muscle function in part when something goes	alled: Hemiplegia, Palsy, gia. Paralysis is the loss of of your body. It happens wrong with the way en your brain and muscles.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A, SUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	8, WING			1	C /05/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		1 10	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF						(XS) COMPLETION DATE
	Paralysis can be compon one or both sides of occur in just one area. This information was of https://medlineplus.go  2. Cerebrovascular di accident: A stroke. We the brain stops. A strombrain attack." If blood than a few seconds, it nutrients and oxygen. lasting damage. This inform the website: https://medlineplus.go  3. Atrial fibrillation: A prhythm of the heartbea obtained from the web <a href="https://www.nlm.nih.gion.html">https://www.nlm.nih.gion.html</a> 4. A. The facility staff if Resident #153 was addiagnoses that include bipolar disease (1) and region, stage 4 (2). Re MDS (minimum data so with an ARD (assessmen of a score of 0 - 15, 12.	plete or partial. It can occur of your body. It can also of or it can be widespread. Obtained from the website:  v/paralysis.html.  sease, infarction or hen blood flow to a part of ke is sometimes called a d flow is cut off for longer he brain cannot get  Brain cells can die, causing oformation was obtained  v/ency/article/000726.htm.  problem with the speed or off. This information was site: ov/medlineplus/atrialfibrillat  failed to implement rehensive care plan for off resident's weights.  mitted to the facility with d but were not limited to off pressure ulcer of sacral sident #153's most recent et), a quarterly assessment ent reference date) of dent #153 as scoring a 12 off or mental status (BIMS) being moderately ily decisions. Section M us having one stage 4	F	656			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		NSTRUCTION		(X3) DATE	SURVEY
		495227	B, WING					C '05/2021
NAME OF P	ROVIDER OR SUPPLIER		<del> </del>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	E	1 10/	03/2021
WESTPO	RT REHABILITATION ANI	NURSING CENTER			FOREST AVE MOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BI		(X5) COMPLETION DATE
	interview was conduct Resident #153 stated weighed since they we and were not sure if the weight. Resident #153 refused for staff to weighed asked for them to The comprehensive condumented in part, "Nesident #153] is at no increased metabolic di w/ (with) quadriplegia stage 4 on sacrum. Revision on: 09/27/202 "Interventions/Tasks" if "Obtain weights as ord loss and weight change 02/17/2021"  The weight summary for documented the most of 3/26/2021 with Resider pounds.  The physician order suffailed to evidence an of for Resident #153.	eximately 3:37 p.m., an eed with Resident #153. Ithat they had not been ere admitted to the facility ley had lost or gained a stated that they never gh them but at times they come back later.  Are plan for Resident #153 NUTRITION: [Name of utritional risk r/t (related to) emands of wound healing, [3], PU (pressure ulcer) ate Initiated: 02/17/2021, 21." Under to documented in part, lered, monitor for weight les, Date Initiated:  Or Resident #153 recent weight obtained on the #153 weighing 197  Armmary dated 10/1/2021 refer for weight monitoring  Resident #153 failed to an of resident refusals for	F	656				
	2/15/2021 for Resident	#153 documented in part, no reports fine appetite,			31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU (DENTIFICATION NUMBER: A, BUILL		TIPLE CON	(X3) DATE SURVEY COMPLETED			
		495227	B. WING				1	05/2021
	ROVIDER OR SUPPLIER	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		Æ	101	vara va s
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI APPROPRIA		(X5) COMPLETION DATE
	dislikes food provided out food for all meals, what is provided. Obta preferences, kitchen or resident on how to cal Denies issues chewin constipation or diarrhediet as ordered: regula ordered, monitor for witch changes. Provide food The progress notes for documented in part the "9/16/2021 12:37 (12 PU to sacrum. No cur 197.0# (3/26/21) Ne wound healing needsContinue CCHO [concontrolled carbohydrat glucose) control, suppremonitor for changes a care) as clinically indictive for the unit nurse mathat the care plan was the staff to communicate residents. LPN #10 stated that residents with weights were docu LPN #10 stated that if weighed they notified to responsible party. LPN #153 frequently refuse	Resident reports ordering states she does not eat ained some food nade aware. Instructed I kitchen and request items. g/swallowing, n/v, ia. Recommend provide ar. Obtain weights as eight loss and weight I preferences as desired"  If Resident #153 is following:  37 p.m.)Skin: Stage 4 rent weight. Last weight: eds increased due to Recs: (recommendations) stant carbohydrate or eight for BG (blood lements for wound healing, and update POC (plan of ated."  D.m., an interview was censed practical nurse) nager. LPN #10 stated a communication tool for the the needs of the ated that the care plan tified nursing assistants) of the resident. LPN #10 ere weighed monthly and mented in the computer. I a resident refused to be the physician and the N #10 stated that Resident d care and their weights ogress notes documenting	F	656				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495227	B. WING	_		10/	05/2021
	ROVIDER OR SUPPLIER RT REHABILITATION AND	NURSING CENTER	g-	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page		F	656			
	conducted with OSM dietician. OSM #8 staresidents in the facility for any significant gair						
	encouraged them to d	f their weights and they ocument the refusals in the #8 stated that Resident					
	because of the pressu weight documentation	re ulcer and the sporadic  OSM #8 stated that they current weight to monitor					
	conducted with LPN # weights were monitored				<u> </u>		
	LPN #8 stated that resulcers required monito	idents who had pressure ring of weights due to LPN #8 stated that when	***		₩ Э		. ·
	documented in the prostated that the care pla	•					
	10/17/2018 documente	ight Management" dated ed in part, "4. Residents					
	of each month with mo	deemed necessary. 5.					
	Weights are verified ar medical record as they interdisciplinary team r resident's care needs t	are obtainedThe entire must be involved in the					
		nember performs tasks					

NAME OF PROVIDER OR SUPPLIER  WESTPORT REHABILITATION AND NURSING CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  A BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  T300 FOREST AVE  RICHMOND, VA 23226  ID PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  TAG CROSS-REFERENCED TO THE APPROPRIATE	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  WESTPORT REHABILITATION AND NURSING CENTER  T300 FOREST AVE RICHMOND, VA 23226  (X4) ID PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  STREET ADDRESS, CITY, STATE, ZIP CODE  7300 FOREST AVE RICHMOND, VA 23226  PROVIDER'S PLAN OF CORRECTION PREFIX  (EACH CORRECTIVE ACTION SHOULD BE	С	
WESTPORT REHABILITATION AND NURSING CENTER  7300 FOREST AVE RICHMOND, VA 23226  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	10/05/2021	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
DEFICIENCY)	(X5) COMPLETION DATE	
F 656 Continued From page 119 consistent with their area of expertise." On 10/4/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the concern.  No further information was provided prior to exit.  4. B. The facility staff failed to implement Resident #153's comprehensive care plan to provide treatments as ordered to Resident #153's pressure ulcor.  The comprehensive care plan for Resident #153 documented in part, "SKIN: [Resident #153] has actual skin breakdown related to sacral pressure ulcer on admission and trauma to left ischium. At risk for further impairment r/l (related to) impaired mobility, incontinence Date Initiated: 02/23/2021, Revision on: 61/4/2021. "Under "Interventions/Tasks" it documented in part, "Name of Wound Care) NP (uruse practitioner) wound care to follow and treatments as ordered Date Initiated: 03/30/2021"  On 9/28/2021 at approximately 3:37 p.m., an interview was conducted with Resident #153. Resident #153 stated that they had an area on their buttocks that they were admitted with that required dressing changes. Resident #153 stated that most of the time the day nurses changed the dressing to the area but there were days when the dressing tho not get changed on the evenings or when the wound nurse was off. Resident #153 stated that they did not refuse wound care because they wanted the area to heal so they would be able to go home.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATÉ COMP	SURVEY LETED
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		495227	B. WING			10/	05/2021
NAME OF P	ROVIDER OR SUPPLIER		·		STREET ADDRESS, CITY, STATE, ZIP CODE	ZIP CODE	
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WESTFOR	KI KENADILITAHUN ANI				RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION OATE
F 656	The physician orders documented in part, "dakins, pack with hyd saline) soaked PACKI with boarder [sic] foar evening shift for wour packing strips, as the pack into her wound Aplease use the packint too large to pack into only for wound care for packing strips, as the pack into her wound.  The eTAR (electronic record) for Resident #8/1/2021-8/31/2021 fa physician ordered treathe sacral pressure ul shift, 8/9/21 on the 3-shift, and 8/28/21 on to The eTAR for Residen 9/1/2021-9/30/2021 fa treatment completed ton 9/7/21 on the 7-3 s 3-11 shift, on 9/13/21 the 3-11 shift, on 9/13/21 on the 3-11 shift, and 9/21/21 on the 3-11 shift a	for Resident #153 SACRUM: Cleanse with rogel AND NS (normal INH [sic] STRIPS, cover in gauze every day and ind care please use the roll gauze is too large to AND as needed for soilage in garries, as the roll gauze is her wound AND one time for 1 Day please use the roll gauze is too large to Order Date: 9/2/2021."  It reatment administration was completed to evidence the atment was completed to cer on 8/5/2021 on the 7-3 and in the 7-3 shift.  Int #153 dated willed to evidence the context of the sacral pressure utcer whift, 9/11/21 on the 7-3 and on the 3-11 shift, 9/17/21 on the 7-3 shift.	F	656			
		d the wound care. LPN #4 care was documented as					

PRINTED: 10/19/2021 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION (X3) DATE SORV COMPLETED C		PLETED	
		495227	B. WING_			10	0/05/2021	
	F PROVIDER OR SUPPLIER PORT REHABILITATION A	ND NURSING CENTER		7300 FC	ADDRESS, CITY, STATE, ZIP CODE DREST AVE IOND, VA 23226			
(X4) ID PREFII YAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULO BE	(XS) COMPLETION DATE	
F 65	performed on the end care were witnessed and documented in reviewed the blanks treatments on the end and stated that they wound care was condocumentation to such the care plan was not treatments were not ordered.  On 9/30/2021 at 1:10 conducted with LPN LPN #10 stated that communication tool the needs of the rest the care plan notified assistants) of any such LPN #10 stated that evidenced as completed or not the treatments were not completed or not treatments were not conducted with LPN conducted with LPN wound care completed or not conducted with LPN wound care completed or not conducted with LPN wound care completed or not conducted with LPN wound care completed or not conducted with LPN wound care completed or not conducted with LPN wound care were deprogress notes. LF	TAR and refusals of wound d by another staff member the progress notes. LPN #4 for physician ordered TARs for Resident #153 for ber of 2021, as listed above, could not evidence that the	F	656		4	PECS WILL	200

completed on the eTAR or in the progress notes

_	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL1	TIPLE (	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A, BUILDII	NG_			С		
		495227	B. WING				10/05/2021		
	ROVIDER OR SUPPLIER			73	REET ADDRESS, CITY, STATE, ZIP COD 00 FOREST AVE CHMOND, VA 23226	E			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI APPROPRIA	COMPLETION OATE		
F 656	they could not say the completed. LPN #8 s was not completed the as ordered was not be.  On 10/4/2021 at application (administrative staff r administrator and AS were made aware of the No further information.  References:  1. Bipotar disorder: (finance-depressive illing a mental disorder the mood, energy, activities ability to carry out information is taken in https://www.nimh.nihorder/index.shtml.  2. Pressure ulcer: is breaks down when s pressing against the grouped by the seventhe mildest stage. St A reddened, painful at turn white when pressure ulcer is form or cool, firm or soft. forms an open sore, may be red and irrited develops an open, s The tissue below the be able to see body The pressure ulcer if	at the wound care was stated that if the wound care le care plan for treatments leing implemented.  Toximately 4:30 p.m., ASM member) #1, the M #2, the director of nursing the concern.  The was provided prior to exit.  Tormerly called less or manic depression) is at causes unusual shifts in the ylevels, concentration, and the day-to-day tasks." This	F	656					

,	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495227	B. WING			l .	05/2021
NAME OF P	ROVIDER OR SUPPLIER	433221	1		STREET ADDRESS, CITY, STATE, ZIP CODE	10/	03/2021
WESTPOR	RT REHABILITATION AND	NURSING CENTER			7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	sometimes to tendons information was obtain https://medlineplus.go 00740.htm.  3. Quadriplegia: "Parfunction in part of you something goes wrong pass between your broad be complete or poon a rea, or it can be the lower half of your called paraplegia." This is quadriplegia." This is quadriplegia." This is the website https://medlineplus.go  5. The facility staff fai #145's comprehensive administration of oxygrate.  Resident #145 was ac diagnoses of but not live respiratory failure, atri hypothyroidism. The state of the condition of the resident was code impaired in ability to make the resident #145 was consistance for bathing	and joints. This med from the website: w/ency/patientinstructions/0 alysis is the loss of muscle r body. It happens when g with the way messages ain and muscles. Paralysis artial. It can occur on one or by. It can also occur in just widespread. Paralysis of body, including both legs, is alysis of the arms and legs information is taken from v/paralysis.html.  Ided to implement Resident e care plan for the ten at the physician ordered dimitted on 9/3/21 with the mitted to COVID-19, al fibrillation, and most recent MDS (Minimum hission assessment with an ference Date) of 9/9/21. The as being cognitively take daily life decisions, aded as requiring extensive	F	656			
	On 9/28/21 at 12:53 P Resident #145 and the conducted. The resident						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILDI		CONSTRUCTION		OMPLETED  C
		495227	B. WING	8. WING 10			
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	,	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 656	oxygen via a nasal ca an oxygen concentrator per minute, as evider set on the 1 liter line of through the center of A review of the clinical physician's order data. Therapy Oxygen at: 2 (nasal cannula)."  A review of the comprevealed one dated of respiratory impairments or a conducted an intervent "Administer oxygen producted with RN (IMDS nurse. RN #2 care plan was to direpatient.  On 10/4/21 at 2:30 Producted with LPN Nurse), the unit man oxygen was set at 1 liters, was the oxyge ordered, was the care plan documents ordered, was the care stated that it was not on 10/4/21 at 5:00 From 10/4	annula that was connected to tor that was running. The flow rate was set at 1 liter need by the flow meter ball with the line positioned it the flow meter ball.  al record revealed a ed 9/4/21 for "Oxygen 2 Liters/minute Via: NC  brehensive care plan 8/13/21 for "Has/At risk for nt related to covid 19. acute th hypoxia." This care plan from dated 9/13/21 for per physician order."  5 p.m., an interview was Registered Nurse) #2, the stated that the purpose of the fact the care of the individual ed. Wh, an interview was fest the care of the individual ed. When asked if the liter and the order was for 2 in being administered as it was not. When asked if the ed to administer oxygen as re plan being followed, she the being followed.  PM, ASM #1 (Administrative dministrator, and ASM #2, the	LL.	656		S	
	Director of Nursing,	dministrator, and ASM #2, the was made aware of the information was provided by					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS	PARTMENT OF HEALTH AND HUMAN SERVICES  NTERS FOR MEDICARE & MEDICAID SERVICES  MENT OF DEFICIENCIES HAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		1 '	IPLE CONSTRUCTION	COMI	E SURVEY PLETED C
			B. WING _		10	/05/2021
	OVIDER OR SUPPLIER	495227  D NURSING CENTER	B. WING	STREET ADDRESS, CITY, STATE, ZIP 0 7300 FOREST AVE RICHMOND, VA 23226	CODE	
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F 656	Continued From pag the end of the surve		F	656		
	incentive spirometer	e plan for the use of an of for Resident #165				
	9/8/21 with the diag atrial fibrillation, stro blood pressure, dial The Admission MDS ARD (Assessment coded Resident #16 ability to make daily was coded as requibathing, hygiene, to assistance for dres coded as incontine	Resident #165 was admitted to the facility on 1/8/21 with the diagnoses of but not limited to trial fibrillation, stroke, aphasia, dysphagia, high blood pressure, diabetes, and hypothyroidism. The Admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/16/21 coded Resident #165 as cognitively impaired in ability to make daily life decisions. Resident #165 was coded as requiring extensive care for pathing, hygiene, toileting, and transfers; limited assistance for dressing and eating; and was coded as incontinent of bowel and bladder.				S.a.
	I always and up in his	PM, Resident #165 was wheelchair in his room eating ed incentive spirometer was wer-bed table.			P	
	observed in his wh	is AM, Resident #165 was neelchair in his room. The er was still on the over-bed When asked if he uses the ter, Resident #165 stated that nes.				
	physician's order Spirometry Instru- mouthpiece in you around it. Breathe	nical record revealed a dated 9/14/21 for "Incentive ct Resident - Place the ur mouth, sealing your lips a in as slowly and deeply as aise the piston toward the top of continue to hold for ~		Facility ID: VA0270	If continuation	sheat Page 126

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL' A, BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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1112	ROVIDER OR SUPPLIER	D NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226				
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F 656	(approximately) 3 sec		F	656			
	plan failed to reveal o an incentive spiromet	#165's comprehensive care ne for the use and care of					
	conducted with RN (F MDS nurse. RN #2 s care plan was to direc patient.	Registered Nurse) #2, the tated that the purpose of the ct the care of the individual					
104	and care of an incenti	•					
	Staff Member) the Ad Director of Nursing, w findings. No further in the end of the survey. 7. The facility staff fail comprehensive care	ed to implement the					
	7/5/21. Resident #22 were not limited to mu and major depressive quarterly minimum da assessment reference resident's cognition as	mitted to the facility on 's diagnoses included but ultiple sclerosis (1), seizures disorder. Resident #22's ta set assessment with an e date of 9/24/21, coded the s severely impaired. ident #22 as having two					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA  DENTIFICATION NUMBER:	(X2) MUL A. BUILO		DINSTRUCTION		SURVEY
		495227	B. WING			1	C /05/2021
	PROVIDER OR SUPPLIER			7300	EET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE HMOND, VA 23226	1	03/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	Review of Resident # the resident was adminjury on the right med Resident #22's clinical #22 acquired a stage sacrum (left buttock) of Resident #22's comproperated to impaired may related to impaired may related to impaired may ressure ulcer (injury) heel wound. Potential (related to) decreased incontinence, nutrition treatment per physicial A physician's order day order to cleanse the risaline, apply Santyl (3) and cover with a dry down the July 2021 TAR (treatment was provide and 7/11/21, as evident #22's clinical treatment was done. In the July 2021 TAR (treatment wa	cies (2).  22's clinical record revealed litted with a stage 3 pressure dial heel. Further review of a record revealed Resident 2 pressure injury (2) on the on 8/17/21.  The ehensive care plan dated Actual skin breakdown obility, admitted with to sacrum, right medial for further impairment r/t imobility, weakness, all needs. Administer in orders"  The ded 7/6/21 documented an apht medial heel with normal aphy calcium alginate (4) record failed to reveal this id on 7/6/21, 7/8/21, 7/10/21 need by blank spaces on atment administration inotes documenting the first treatment was 21.  The ded 7/15/21 documented an apht medial heel with normal aphy calcium the ordered gauze every ent #22's clinical record atment was provided on	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B, WING		<del></del>	1	C 05/2024
NAME	OF PROVIDER OR SUPPLIER	700227		s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	05/2021
WES	TPORT REHABILITATION AN	D NURSING CENTER		ı	300 FOREST AVE RICHMOND, VA 23226		
(X4) PRE TA	FIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F	order to cleanse their saline, apply medihor and secure with border Review of Resident # reveal this treatment 8/28/21, 8/29/21, 8/31 9/9/21, as evidenced August 2021/Septeminurses' notes documed done.  A physician's order dayorder to cleanse their saline, apply medihon bordered gauze every #22's clinical record fay was provided on 8/29/9/21, as evidenced August 2021/Septeminurses' notes documed done.  On 9/30/21 at 10:37 a conducted with LPN (ILPN #7 stated the factureses but the nurses need to provide wound nurses are not available care treatments should TAR. LPN #7 further streatment was provider regards to the purpose stated, "A care plan is patient; how best for use a stated to the purpose stated, "A care plan is patient; how best for use a stated to the purpose stated," A care plan is patient; how best for use a stated to the purpose stated."	ated 8/15/21 documented an ight medial heel with normal ley, apply silver alginate (4) ared gauze every day. 22's clinical record failed to was provided on 8/25/21, //21, 9/1/21, 9/7/21 and by blank spaces on the per 2021 TARs and no enting the treatment was ated 8/24/21 documented an eff buttock with normal ley and secure with day. Review of Resident liled to reveal this treatment (21, 9/1/21, 9/7/21 and by blank spaces on the ler 2021 TARs and no noting the treatment was licensed practical nurse) #7. If yemploys wound care on the medication carts if care if the wound care le. LPN #7 stated wound is be documented on the stated nurses cannot say dif it is not documented. In of a care plan, LPN #7	F	656			

	TO TOTA MEDIONATE G	MEDIO/AD OCITATOCO				ONID 140. 00	30-0331
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			(X3) DATE SURY COMPLETE	
]		495227	B. WING			C 10/05/2	021
	ROVIDER OR SUPPLIER	D NURSING CENTER	7300	EET ADDRESS, CITY, STATE 3 FOREST AVE HMOND, VA 23226	, ZIP CODE	1 10/03/2	021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD 8 D TO THE APPROPRI CIENCY)	- 1	(KS) MPLETION DATE
F 656	the patient by looking On 10/4/21 at 3:30 p.r. conducted with LPN # implementation. LPN depends on the nurse residents, I look at the especially when I don' On 10/4/21 at 4:40 p.r. staff member) #1 (the (the director of nursing above concern.	m so they can get to know at the paper"  n., another interview was 7, regarding care plan #7 stated, "I guess it really When I'm taking care of ir chart and their care plan,	F 656				
	disease that affects yo damages the myelin si surrounds and protects information was obtain https://vsearch.nlm.nih meta?v%3Aproject=mmedlineplus-bundle&q.747995928,163353868  (2) "A pressure injury is skin and underlying so bony prominence or redevice. The injury can open ulcer and may be as a result of intense a or pressure in combinatolerance of soft tissue	a.gov/vivisimo/cgl-bin/query-edlineplus&v%3Asources= uery=ms&_ga=2.53710894 18-221748656.163353861  Is localized damage to the fit tissue usually over a lated to a medical or other present as intact skin or an e painful. The injury occurs ind/or prolonged pressure					si .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MI IDENTIFICATION NUMBER: A, BUIL			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION							С	
		495227	B, WING	_		10	0/05/2021	
NAME OF P	ROVIDER OR SUPPLIER			П	STREET ADDRESS, CITY, STATE, ZIP CODE			
WESTER	RT REHABILITATION AN	D MILIDRING CENTED		1	7300 FOREST AVE			
1123770	KI KENABILMANION ANI	D NORSING CENTER			RICHMOND, VA 23226			
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F 656	Continued From page	130	_	65	36			
		ies and condition of the soft	- F	00	,0			
	tissue.	ies and condition of the son	İ				-	
		ry: Partial-thickness skin			İ			
	loss with exposed der							
	Partial-thickness loss		-					
		ed is viable, pink or red,						
79	moist, and may also p				<u> </u>			
	ruptured serum-filled b		1				i	
	Stage 3 Pressure Injur	ry: Full-thickness skin loss						
2		skin, in which adipose (fat)					ŀ	
	is visible in the ulcer a	nd granulation tissue and						
9		edges) are often present."						
		btained from the website:	İ					
		n/npiap.com/resource/resm						
1	gr/online_store/npiap_	pressure_injury_stages.pdf					l	
1	(3 "SANTYL Ointment	is an FDA-approved	1					
	*	that removes dead tissue						
1	from wounds so they o							
	information is taken fro	om the manufacturer's		-			(0)	
	website https://www.sa	antyl.com/.	1		5" 249 21	•		
	(4) *Alginata draggings	are absorbent wound care						
1		odium and calcium fibers	1					
		. They come in the form of						
		be placed over open ulcers	ĺ					
		it are used for packing the						
		luids and promote healing						
	with pressure ulcers, d	iabetic foot utcers, or						
	venous ulcers. An indiv	/idual dressing is able to						
	absorb up to 20 times i	ts own weight. These						
	dressings, which are ea							
	themselves to the shap							
		absorb wound drainage						
		es these dressings ideal						
	•	reas that are difficult to						
- 1	dress, such as heels ar							
111	information is taken fro	,	1					
-	nttps://advancedtissue.	.com/2015/09/treating-wou						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	8. WNG			40//	05/2021
	ROVIDER OR SUPPLIER			ST 73	REET ADDRESS, CITY, STATE, ZIP CODE 600 FOREST AVE ICHMOND, VA 23226	10/0	75/2021
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F 656	wound treatment. The from the website:	ginate-dressings/. lical grade honey used for is information was obtained nih.gov/pmc/articles/PMC26		656	1. Resident #160 no longer resi	ides	
SS=E	CFR(s): 483.21(b)(2)(2)(4)(4)(2)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	ensive Care Plans brehensive care plan must days after completion of essessment. erdisciplinary team, that ited to- esician. with responsibility for the responsibility for the and nutrition services staff. dicable, the participation of esident's representative(s). be included in a resident's contribution of the resident resentative is determined development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary essment, including both the			in the center. Resident #22, #45, #82, #153, #145 and #165 care plans have updated to represent comprehensive of care.  2. Ensure all current residents residing in center reviewed to ensure comprehensive care plan is established and implemented.  3. DON or designee will educate facility nursing staff to ensure understanding and requirements for implementation of comprehensive care plans.  4. DON or designee will audit 1 all residents to ascertain development implementation of comprehensive care weekly times 4 weeks and monthly ting to ensure facility maintains the development/Implementation of comprehensive care Plans. Any identissues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months.  5. Date of compliance will be	e been plan ed te all ee ow of t and re plan ees 2	71/19/21

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY	
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		495227	B, WING			10/05/2021		
NAME OF P	ROVIDER OR SUPPLIER			ı	EET ADDRESS, CITY, STATE, ZIP CODE			
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	by: Based on observation document review, clinithe course of a comple determined that the fa and revise the compre of 84 residents in the state of 84 residents in the state of 84 residents in the state of 84 residents in the state of 84 residents in the state of 84 resident staff falle.  1. The facility staff falle restrained on 5/6/21, a post the incident.  2. The facility staff faile Resident #91's compre following the resident shis wall on 6/21/21.  3. The facility staff falle Resident #111's compresident fell on 7/6, 4. The facility staff falle Resident #65's compre resident fell on 6/17/21.  5. The facility staff falle Resident #21's compresident fell on 1/5/21, 7. The facility staff falle Resident #19's compresident fell on 1/5/21, 7. The facility staff falle comprehensive care plinclude the use of bed 8. The facility staff falle Resident #47's compr	n, staff interview, facility ical record review, and in aint investigation, it was cility staff failed to review thensive care plan for eight survey sample, Residents #21, #19, #155, and #47.  ed to review and revise rehensive care plan to reing found physically and the resident care needs are do review and revise and revise and review and revise and to review and revise and to review and revise rehensive care plan after /21 and 7/7/21.  ed to review and revise rehensive care plan after /21 and 7/7/21.  ed to review and revise rehensive care plan after the info/24/21 and 6/25/21.  ed to review and revise rehensive care plan after the 2/16/21 and 3/15/21.  ed to review and revise rehensive care plan after the 2/16/21 and 3/15/21.  ed to review and revise rehensive care plan after the 2/16/21 and 3/15/21.	F	657				
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION		<u>-l</u>	7:	TREET AODRESS, CITY, STATE, ZIP CODE 300 FOREST AVE RICHMOND, VA 23226	1 10/	03/2021
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL, R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
4/27/16, and most with diagnoses inch and arthritis. She won 6/12/21.  On the most recent quarterly assessme reference date) of 6 coded as being sev making daily decising 15 on the BIMS (bright she was coded as restraints during the A review of Resider revealed the following 5/6/21: "[Resident flow wristband attached article of clothing. Than a skin assessme integrity issues noted a regarding physical restraints.  On 9/30/21 at 11:52 nurse) #15 was interesident's care plan interventions neces resident. When ask updating a resident' "I think it is the nurs unclear who is respending a resident" "I think it is the nurs unclear who is respending a resident".	as admitted to the facility on ecently readmitted on 12/9/20, uding dementia with behaviors as discharged from the facility  MDS (minimum data set), a mit with an ARD (assessment /8/21, Resident #502 was erely cognitively impaired for ons, having scored one out of ef interview for mental status), not being placed in physical look back period.  It #502's clinical recording progress note, dated 502] was observed with to the arm rail of her bed via the wristband was removed ent was completed. No	F	657			

F 657 Continued From page 134 the nurse working with the resident at the time may be responsible for updating the care plan at that time, but she was not certain.  On 9/30/21 at 12:06 p.m., LPN #7, a unit manager, was interviewed. She stated the restraint incident for Resident #502 should have been added to the care plan LPN #7 stated staff should have been alerted on the care plan to assess the resident's psychosocial well-being, and her skin.  On 10/4/21 at 10:34 a.m., OSM (other staff member) #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days, She stated she could not speak to anything that was or was not done prior to her arrival at the facility. When asked if the social worker is involved in updating a resident's care plan, she stated she was not sure.  On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. When asked who is responsible for updating a resident's care plan, ASM #2 stated		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A, BUIL		CONSTRUCTION	(X3) DATE COMP	LETED
NAME OF PROVIDER OR SUPPLIER  WESTPORT REHABILITATION AND NURSING CENTER  SIMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 657  Continued From page 134 the nurse working with the resident at the time may be responsible for updating the care plan at that time, but she was not certain.  On 9/30/21 at 12:06 p.m., LPN #7, a unit manager, was interviewed. She stated the restraint incident for Resident #502 should have been added to the care plan. LPN #7 stated staff should have been alterted on the care plan to assess the resident's psychosocial well-being, and her skin.  On 10/4/21 at 10:34 a.m., OSM (other staff member) #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she rould not speak to anything that was or was not done prior to her arrival at the facility. When asked if the social worker is involved in updating a resident's care plan, she slated she was not sure.  On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. When asked who is responsible for updating a resident's care plan, asked who is responsible for updating a resident's care plan, ASM #2 stated			405227	B. WING	;		ı	
WESTPORT REHABILITATION AND NURSING CENTER  TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 657  Continued From page 134 the nurse working with the resident at the time may be responsible for updating the care plan at that time, but she was not certain.  On 9/30/21 at 12:06 p.m., LPN #7, a unit manager, was interviewed. She stated the restraint incident for Resident #502 should have been added to the care plan LPN #7 stated staff should have been alerted on the care plan to assess the resident's psychosocial well-being, and her skin.  On 10/4/21 at 10:34 a.m., OSM (other staff member) #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days, She stated she could not speak to anything that was or was not done prior to her arrival at the facility. When asked if the social worker is involved in updating a resident's care plan, she stated she was not sure.  On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. When asked who is responsible for updating a resident's care plan, ASM #2 stated	NAME OF PI	ROVIDER OR SUPPLIER	433221			TREET ADDRESS, CITY, STATE, ZIP CODE	1 107	V-1/2-02-1
PREFIX TAG EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 657  Continued From page 134 the nurse working with the resident at the time may be responsible for updating the care plan at that time, but she was not certain.  On 9/30/21 at 12:06 p.m., LPN #7, a unit manager, was interviewed. She stated the restraint incident for Resident #502 should have been added to the care plan. LPN #7 stated staff should have been added to the care plan to assess the resident's psychosocial well-being, and her skin.  On 10/4/21 at 10:34 a.m., OSM (other staff member) #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to anything that was or was not done prior to her arrival at the facility. When asked if the social worker is involved in updating a resident's care plan, she stated she was not sure.  On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. When asked who is responsible for updating a resident's care plan, ASM #2 stated			D NURSING CENTER					
the nurse working with the resident at the time may be responsible for updating the care plan at that time, but she was not certain.  On 9/30/21 at 12:06 p.m., LPN #7, a unit manager, was interviewed. She stated the restraint incident for Resident #502 should have been added to the care plan. LPN #7 stated staff should have been alerted on the care plan to assess the resident's psychosocial well-being, and her skin.  On 10/4/21 at 10:34 a.m., OSM (other staff member) #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to anything that was or was not done prior to her arrival at the facility. When asked if the social worker is involved in updating a resident's care plan, she stated she was not sure.  On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. When asked who is responsible for updating a resident's care plan, ASM #2 stated	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	E ATE	COMPLETION
nurses, the social worker, and the MDS nurse may all update a resident's care plan. ASM #2 stated Resident #502's care plan should have been updated with the restraint incident.  On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns.  A review of the facility policy, "Care Conference," revealed, in part: "The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team which includes, but is not necessarily	F 657	the nurse working with may be responsible for that time, but she was On 9/30/21 at 12:06 p manager, was intervier estraint incident for F been added to the car should have been ale assess the resident's and her skin.  On 10/4/21 at 10:34 a member) #4, the direct interviewed. She state working at the facility she could not speak to not done prior to her a asked if the social wo a resident's care plan sure.  On 10/4/21 at 3:39 put staff member) #2, the interviewed. When as updating a resident's nurses, the social wo may all update a resident's tated Resident #502 been updated with the On 10/4/21 at 5:06 put administrator, was information of the facility revealed, in part: "The resident's comprehendeveloped by a Care	th the resident at the time or updating the care plan at a not certain.  I.m., LPN #7, a unit exed. She stated the Resident #502 should have re plan. LPN #7 stated staff rted on the care plan to psychosocial well-being,  I.m., OSM (other staff ctor of social services, was ead she had only been for three days. She stated to anything that was or was arrival at the facility. When river is involved in updating, she stated she was not  I.m., ASM (administrative director of nursing, was ked who is responsible for care plan, ASM #2 stated river, and the MDS nurse dent's care plan. ASM #2 stated river, and the MDS nurse dent's care plan should have a restraint incident.  I.m., ASM #1, the ormed of these concerns.  I. policy, "Care Conference," a care plan is based on the sive assessment and is Planning/Interdisciplinary	F	: 657			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
495227 B. WING				l .	C 10/05/2021			
NAME OF B	2011052 02 01 02 150	100221			ATD COT 1 D CO C C C C C C C C C C C C C C C C C	10/	05/2021	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
WESTPOR	RT REHABILITATION ANI	D NURSING CENTER			7300 FOREST AVE			
1	· · · · · · · · · · · · · · · · · · ·	THORONG GENTER		l	RICHMOND, VA 23226			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	10		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
			1		55, 10,000			
			ĺ			1		
F 657	Continued From page	135	F	65	7	- 8		
l ,	limited to the following	personnel:				3		
	a. The resident's Atter							
		rse who has responsibility				3		
	for the resident;							
	c. The Dietary Manag	er/Dietitian;						
	d. The Social Services	s Worker responsible for the						
	resident;	·				Į.		
	e. The Activity Directo	r/Coordinator;				- 1		
	f. Therapists (speech,	occupational, recreational,						
	etc.), as applicable;					3		
i	g. Consultants (as app	oropriate);				3		
	h. The Director of Nurs	sing (as applicable);						
	i. The Charge Nurse re	esponsible for resident				3		
	саге;							
	j. Nursing Assistants re	esponsible for the resident's						
	care; and		1					
	k. Others as appropria	ite or necessary to meet the				1	2	
	needs of the resident,					3		
1.01		sident's family and/or the				0.5		
	resident's legal repres				9.			
	•	ged to participate in the						
	•	visions to the resident's					:	
[	care plan."							
	No further information	was provided prior to exit.						
	Complaint Deficiency						1	
	O Desident MA4	admitted the short for 1915 and				- 5		
-	5.9	admitted to the facility on						
	12/15/20, and most red	•						
1	•	s including diabetes and						
		on the most recent MDS						
I .	(minimum data set), a	-						
		RD (assessment reference						
		lent #91 was coded as						
		pairment for making daily						
	decisions, having score					3		
	BIMS (brief interview for	or mental status).						
			1		1		1	

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	C	X3) DATE SURVEY COMPLETED	
	495227	B, WING			С	
AME OF PROVIDER OR SUPPLIER	453227	10.41110_	STREET ADDRESS, CITY, STATE, ZIP CO		10/05/2021	
ESTPORT REHABILITATION AN	D NURSING CENTER		7300 FOREST AVE RICHMOND, VA 23226			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATI	(X5) COMPLETION E DATE	
at the beginning of the witnessed punching hof anger. Resident co swelling, pain, and dismotion)."  Further review of Resident #S A review of Resident	#91's clinical record note dated 6/21/21: erbal, observed to be angry a shift. Resident was its left hand on the wall out implains of left hand scomfort on ROM (range of ident #91's clinical record formed on 6/21/21 91's left hand was broken.  #91's comprehensive care ind updated 8/27/21 failed to inted to the 6/21/21 incident.  Im., LPN (licensed practical lewed. She stated a corporates orders and ry to provide care for a who is responsible for care plan, she stated: "I lanager." She stated it is sible for updating the care it like a fall. She stated the resident at the time may ating the care plan at that certain.  Im., OSM (other staff tor of social services, was	F	557			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		E SURVEY PLETED
		495227	B. WING			10	C /05/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		1 10	103/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	staff member) #2, the interviewed. When as reviewing and revising ASM #2 stated nurses MDS nurse may all up ASM #2 stated Residuate plan should have angry outburst and had On 10/4/21 at 5:06 p.r administrator, was information. When the properties of the properties of the properties of the properties of the properties of the properties of the properties of Resident #1 was 5/24/21. Resident #11 was 5/24/21. Resident #11 was 5/24/21. Resident #11 were not limited to dia anxiety disorder. Resiminmum data set ass assessment reference resident's cognition as Section J coded Residuation of Resident #1 revealed nurses' notes resident felt on 7/6/21. Review of Resident #1 Review of Resident #1	m., ASM (administrative director of nursing, was ked who is responsible for g a resident's care plan, s, the social worker, and the odate a resident's care plan. ent #91's comprehensive been updated after his and fracture.  m., ASM #1, the ormed of these concerns.  was provided prior to exit.  admitted to the facility on 11's diagnoses included but betes, dementia and ident #111's quarterly essment with an date of 8/28/21, coded the severely impaired. Item #111 as having falls since admission or  11's clinical record at that documented the and 7/7/21.  11's comprehensive care end to reveal the care plan	F.	657			
	On 9/30/21 at 10:37 a.	m., an interview was censed practical nurse) #7.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		LE CONSTRUCTION	(X3) DATE	SURVEY PLETED	
						200	C	
		495227	B. WING	_		10/05/2021		
NAME OF P	ROVIDER OR SUPPLIER			П	STREET ADDRESS, CITY, STATE, ZIP CODE			
WESTRO	RT REHABILITATION AND	NI IPSING CENTER			7300 FOREST AVE			
11201101	N KENADIENAHON AND	NORSING CEATER		RICHMOND, VA 23226				
(X4) ID		ATEMENT OF DEFICIENCIES	(D		PROVIDER'S PLAN OF CORRECTION		(XS) COMPLETION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI		DATE	
					DEFICIENCY)			
F 657	Continued From page		F	657	7			
		e plan is individualized to						
		t for us to take care of						
		we have so much agency.	1		20			
	•	or them so they can get to	4		1			
		oking at the paper. Also,						
		ent future incidences such ed a resident's care plan						
		ed a resident's care plan nd revised after each fall.						
}	SHOULD DO ICHICANDO SI	IC 10 1300 alto: Caci Iali.						
	On 10/4/21 at 11:25 a.	.m., ASM (administrative						
		administrator) and ASM #2						
		g) were made aware of the						
	above concern.							
į								
	No further information	was presented prior to exit.						
	4 Resident #65 was a	idmitted to the facility on						
		65's diagnoses included but						
		betes, breast cancer and			D D D D			
	muscle wasting. Residen				1		-11	
(A)	minimum data set assi			-	19 8	277	*.	
	assessment reference	date of 8/5/21, coded the						
	resident's cognition as	severely impaired.						
		sident as having sustained						
		admission or the prior						
ľ	assessment.							
	Pavious of Pasidant #6	5's clinical record revealed						
		umented Resident #65 felt					ı	
1	on 6/17/21, 6/24/21 an							
	011 0/ 17/21, 012+/21 dil	14 0/20/E1.			RAPE SEE SEE SEE SEE SEE SEE SEE SEE SEE S		•	
	Review of Resident #6	5's comprehensive care			#			
	plan dated 1/11/21 faile	ed to reveal the care plan						
	was reviewed or revise	ed for the 6/17/21, 6/24/21						
	and 6/25/21 falls.				1			
	0.00004 110.00							
	On 9/30/21 at 10:37 a.	The state of the s						
		censed practical nurse) #7.			* 0 m c c			
	LITIN #1 Stated, "A care	plan is individualized to			1			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A, BUILDING	CONSTRUCTION		DATE SURVEY COMPLETED			
		495227	B. WING		C 10/05/2021				
ĺ	PROVIDER OR SUPPLIER	NURSING CENTER	S 7: R		10,000,2021				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD					
F 657	each patient; how bes them, especially since It's a great resource for know the patient by lot it's meant to help previous falls." LPN #7 state should be reviewed and On 10/4/21 at 11:25 at staff member) #1 (the (the director of nursing above concern.  No further information  5. Resident #21 was at 8/4/20. Resident #21 was at 8/4/20. Resident #21 were not limited to a him and diabetes. Resident data set assessment with reference date of 7/9/2 being cognitively intaction.  On 9/28/21 at 12:21 p. observed lying in bed wurght position.  Review of Resident #2 a physician's order dat rails as enablers to turn.  Review of Resident #2 plan dated 8/5/20 failled regarding the use of bed on 9/30/21 at 10:37 at conducted with LPN (lief.)	at for us to take care of the we have so much agency. For them so they can get to oking at the paper. Also, ent future incidences such ad a resident's care plan and revised after each fall.  I.M., ASM (administrative administrator) and ASM #2 (a) were made aware of the was presented prior to exit.  I. dmitted to the facility on a diagnoses included but istory of stroke, paralysis at #21's quarterly minimum with an assessment 11, coded the resident as it.  I. m., Resident #21 was with two 1/2 bed rails in the 1's clinical record revealed and reposition.  I's comprehensive care if to reveal documentation and rails.	F 657						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1	LE CONSTRUCTION	_		SURVEY PLETED
	495227 B. WING				1	C	
NAME OF F	PROVIDER OR SUPPLIER	433221		STREET ADDRESS, CITY, S	STATE, ZIP CODE	1 10	/05/2021
WESTPO	RT REHABILITATION AND	NURSING CENTER		7300 FOREST AVE RICHMOND, VA 23226	<b>i</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRI	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	each patient; how besthem, especially since It's a great resource for know the patient by low 75 stated residents' careviewed and revised rails.  On 10/4/21 at 11:25 at staff member) #1 (the (the director of nursing above concern.  No further information  6. Resident #19 was at 4/10/17. Resident #19 was at 4/10/17. Resident #19 was at 4/10/17. Resident #19 was at 4/10/17. Resident #19 was at 4/10/17. Resident #19 was at 4/10/17. Resident #19 was at 4/10/17. Resident #19 was at 4/10/17. Resident #19 was at 4/10/17. Resident #19 was resident's cognition as Section J coded Resident #19 was at 1/5/21, 2/16/21 and Review of Resident #19 plan dated 11/1/20 falled was reviewed or revised and 3/15/21 falls.  On 9/30/21 at 10:37 at conducted with LPN (lie	it for us to take care of we have so much agency, or them so they can get to oking at the paper" LPN are plans should be to include the use of bed  Im., ASM (administrative administrator) and ASM #2 p) were made aware of the was presented prior to exit.  Idmitted to the facility on be diagnoses included but sole weakness, repeated essure. Resident #19's a set assessment with an date of 7/8/21, coded the severely impaired, ent #19 as not having the prior assessment.  9's clinical record revealed amented the resident fell 3/15/21.  9's comprehensive care and for the 1/5/21, 2/16/21	F 657	7			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD	TIPLE CONSTRUCTION NG		(X3) DATE : COMPI	
		495227	B. WING			10/0	) 05/2021
	ROVIDER OR SUPPLIER	NURSING CENTER	·	STREET ADDRESS, CITY, S 7300 FOREST AVE RICHMOND, VA 23226		1 1011	5572521
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRI	TS PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	It's a great resource for know the patient by loit's meant to help previous falls." LPN #7 state should be reviewed and On 10/4/21 at 11:25 at staff member) #1 (the (the director of nursing above concern.  No further information 7. Resident #155 was diagnoses that include paraplegia (1) and may Resident #155's most data set), a quarterly at (assessment reference Resident #155 as scor assessment for mental of 0 - 15, 14- being conducted with Resident #155 bed rails in place. At the conducted with Resident #155 bed rails in place. At the conducted with Resident with bilateral upper side conducted on 9/29/202 The comprehensive cardocumented in part, "A living) Self-care deficit	we have so much agency. In them so they can get to oking at the paper. Also, ent future incidences such ad a resident's care plan and revised after each fall.  Im., ASM (administrative administrator) and ASM #2 (administrator) and Facility with doubt were not limited to for depressive disorder (2), recent MDS (minimum assessment with an ARD added) of 9/13/2021, coded ing a 14 on the staff at status (BIMS) of a score contively intact for making p.m., an observation was an interview was an the status of the status	F	557			

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD	TIPLE CONSTRUCTION	·	(X3) DATE SURVEY COMPLETED
			1,00,00			С
		495227	B. WING		_	10/05/2021
	F PROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STA 7300 FOREST AVE RICHMOND, VA 23226	TE, ZIP CODE	
(X4) IE PREFI TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)	
F 65	activities but dep (dep activities due to contro chronic pain syndrom Initiated: 04/19/2021, The ADL care plan fai bed rails for Resident  The admission resided 4/9/2021 for Resident "Bed rail risks, bene discussed with the parepresentative. Bed rat this time. Consent Patient/Resident"  On 10/4/2021 at 11:36 conducted with LPN (I LPN #8 stated that cal LPN #8 stated that the responsible for the base MDS (minimum data is comprehensive care pupdate. LPN #8 stated bed rails should have)  On 10/4/2021 at 2:15 conducted with RN (ref (minimum data set) nutries.)	pendent) for LB (lower body) actures and paraplegia e decreased mobility. Date Revision on: 09/16/2021." led to evidence the use of #155.  Intervaluation dated #155 documented in part, fits, and precautions were tient and/or patient all(s) is/are recommended obtained from:  S. a.m., an interview was icensed practical nurse) #8. Ire plans were a team effort. In enurse manager was seline care plan and the selan which the nurses could did that residents who utilized them on their care plans.	F	657	EFICIENCY)	
	the individual patient. plans were created by and that they reviewed assessment summary assessment to direct ti place. RN #2 stated th care plan addressing to On 10/4/2021 at 3:06	RN #2 stated that the care the interdisciplinary team I the CAAS (care area ) from the MDS he care plans they put into nat residents should have a heir use of bed rails.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		CONSTRUCTION	ON			(X3) DATE COMP	SURVEY PLETEO
		495227	B. WING					C 10/05/2021		
	ROVIDER OR SUPPLIER	NURSING CENTER	1 %	73	REET ADDRES 00 FOREST A	VE	TE, ZIP CODE	₿	107	03/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)				SHOULD B		(X5) COMPLETION DATE
1	the needs of the resid the care plan notified assistants) of any spe LPN #10 stated that be care plan and were a LPN #10 stated that Reshould include bed rail. On 10/5/2021 at approrequest was made to member) #2, the direct policy on care planning the facility used Lippin standard of practice.  The facility policy "Care Team" documented in based on the resident assessment and is der Planning/Interdisciplinal According to Fundame Williams and Wilkins 2 documented, "A writted communication tool and members that helps er careThe nursing care information about the pand goals. It contains achieving the goals es the patient and is used review, revise and upd when there are change and with new orders"	re care plan was a re the staff to communicate ents. LPN #10 stated that the CNA's (certified nursing clal needs of the resident. ed rails were included in the part of the ADL care plan. desident #155's care plan desident #155	F	657			8			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/19/2021 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A, BUILDING \_ 495227 B. WING 10/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE WESTPORT REHABILITATION AND NURSING CENTER RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) Continued From page 144 F 657 administrator and ASM #2, the director of nursing were made aware of the concern. No further information was provided prior to exit. References: 1. Paralysis: is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia. This information is taken from the website https://medlineplus.gov/paralysis.html. 2. Major depressive disorder: is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm. 8. Resident #47 was admitted to the facility on 7/19/21 with the diagnoses of but not limited to metabolic encephalopathy, chronic obstructive pulmonary disease, congestive heart failure, atrial fibrillation, somatoform disorder, angina, depression, Insomnia, high blood pressure, end stage renal disease, and dysphagia. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 7/22/21. The resident was coded as being cognitively impaired in ability to make daily life decisions. The

resident was coded as requiring extensive

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		LE CONSTRUCTION		SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 101	100/2021
	RT REHABILITATION ANI	NURSING CENTER		,	7300 FOREST AVE RICHMOND, VA 23226		
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	all other areas of active A review of the comprevealed one dated 7/has Renal insufficience failure, requires encouresident frequently refincluded dialysis-specification of transport center on Dialysis day access site for lack of infection, swelling or efacility guidelines. Rephysician dated 7/20/and/or dialysis treatmed changes in medication times/dosage pre-dialy 7/20/21; and "Coordinalistication of the survey date remained current and record.  A review of the clinical note dated 9/6/21 that alert and verbal, dialys was advised that residue to better labs [labor Daughter (name) and laware."  Further review of the cophysician's progress in documented, "The henremoved today."	rs and limited assistance for rities of daily living.  ehensive care plan 20/21 for "(Resident #47) y related to chronic renal tragement to attend as uses." This care plan ific interventions of: ation to and from Dialysis s" dated 7/20/21; "Check thrill/bruit, evidence of xcessive bleeding per port abnormalities to 21; "Confer with physician ent center regarding a administration risis as needed" dated ate dialysis care with the left" dated 7/20/21.  10/4/21, this care plan active on the clinical  record revealed a nurse's documented, "Resident is its called this AM, writer ent does not need dialysis pratory tests] results.  MD (medical doctor)  linical record revealed a pote dated 9/17/21 that nodialysis catheter will be	F	657			
	On 10/4/21 at 2:30 PM	, an interview was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ., .	(2) MULTIPLE CONSTRUCTION  . BUILDING		(X3) DATE : COMPL	
		495227	B. WING			C 10/05/2021	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 1010	7072021
MEGTROE	T DELIA DU ITATION AN	DALIDONIC OCNITED		73	300 FORESTAVE		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		R	ICHMOND, VA 23226		
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F 658 SS=D	Nurse), the unit manaresident was no long if the care plan should reflect that the reside LPN #8 stated that it  On 10/4/21 at 5:00 P Staff Member) the Act Director of Nursing, with the end of the survey Services Provided McCFR(s): 483.21(b)(3) Compositive end of the survey Services Provided McCFR(s): 483.21(b)(3) Compositive end of the survey Services Provided as outlined by the commustive end of the services provide as outlined by the commustive end on resident in clinical record review it was determined that follow professional stof 84 residents in the #153, and #129.  The facility staff failed physician order for Al and failed to transcrib treatment of Resident.	#8 (Licensed Practical ager. She verified that the er on dialysis. When asked dhave been updated to not was no longer on dialysis, should have been.  M, ASM #1 (Administrative Iministrator, and ASM #2, the was made aware of the information was provided by the facility, mprehensive Care Plans dor arranged by the facility, is not met as evidenced atterview, staff interview, and facility document review at the facility staff failed to andards of practice for two survey sample, Resident #153, be a telephone order for t #129's pressure ulcer. (1)		658	1. Resident #129 no longer resides in center. Resident #153 order was clarit upon notification of finding. 2. Review of all resident's medication to ensure free of duplication and all curesidents with wounds have accurate treatment orders. 3. DON or designee will educate all fa nursing staff to review policy on clarific of physician orders when duplicates p and transcription of treatment orders for pressure ulcers. 4. DON or designee will audit 10% of residents to ascertain free of duplicate medication orders and active treatmer orders in place for all wounds weekly weeks and monthly times 2 to ensure is executing physician to meet profess standards. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance commit analysis and revision x 3 months. 5. Date of compliance will be	cility cation resent or all times 4 facility sional e	11/19/21
		is admitted to the facility with led but were not limited to					

NAME OF PROVIDER OR SUPPLIER  WESTPORT REHABILITATION AND NURSING CENTER  (X4) ID PREFIX TAG  (X4) ID PREFIX TAG  (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 658  Continued From page 147 bipolar disease (1) and pressure ulcer of sacral region, stage 4 (2).  Resident #153's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 91/3/2021, coded Resident #153 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions.  The physician order summary dated 9/29/2021 documented in part the following:  - "Alprazolam Tablet 0.5 mg (milligram) Give 2 (two) tablet by mouth two times a day for anxiety. Verbal. Order Date: 09/24/2021."  - "Alprazolam Tablet 0.5 mg Give 2 tablet by mouth two times a day for anxiety related to anxiety disorder, unspecified. Prescriber Entered. Order Date: 09/24/2021."	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILD		CONSTRUCTION		COMPLETED		
NAME OF PROVIDER OR SUPPLIER  WESTPORT REHABILITATION AND NURSING CENTER  (X4) ID PREFIX TAG  (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 658  Continued From page 147  bipolar disease (1) and pressure ulcer of sacral region, stage 4 (2).  Resident #153's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/13/2021, coded Resident #153 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making dally decisions.  The physician order summary dated 9/29/2021 documented in part the following:  - "Alprazolam Tablet 0.5 mg (milligram) Give 2 (two) tablet by mouth two times a day for anxiety. Verbal. Order Date: 99/24/2021."  - "Alprazolam Tablet 0.5 mg (sive 2 tablet by mouth two times a day for anxiety related to anxiety disorder, unspecified. Presoriber			495227	B. WING			10	-		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)  F 658  Continued From page 147 bipolar disease (1) and pressure ulcer of sacral region, stage 4 (2).  Resident #153's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/13/2021, coded Resident #153 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making dally decisions.  The physician order summary dated 9/29/2021 documented in part the following: - "Alprazolam Tablet 0.5 mg (milligram) Give 2 (two) tablet by mouth two times a day for anxiety. Verbal. Order Date: 09/24/2021." - "Alprazolam Tablet 0.5 mg Give 2 tablet by mouth two times a day for anxiety related to anxiety disorder, unspecified. Prescriber			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226 RY STATEMENT OF DEFICIENCIES  O PROVIDER'S PLAN OF CORRECTION			,				
bipolar disease (1) and pressure ulcer of sacral region, stage 4 (2).  Resident #153's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/13/2021, coded Resident #153 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions.  The physician order summary dated 9/29/2021 documented in part the following:  - "Alprazolam Tablet 0.5 mg (milligram) Give 2 (two) tablet by mouth two times a day for anxiety.  Verbal. Order Date: 09/24/2021."  - "Alprazolam Tablet 0.5 mg Give 2 tablet by mouth two times a day for anxiety related to anxiety disorder, unspecified. Prescriber	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	3E	COMPLETION		
The eMAR (electronic medication administration record) dated 9/1/2021-9/30/2021 for Resident #153 documented in part the following:  - "Alprazolam Tablet 0.5 mg Give 2 tablet by mouth two times a day for anxiety related to Anxiety Disorder, unspecified. Start Date:  09/25/2021 2100 (9:00 p.m.)." Administered at 0900 (9:00 a.m.) and 2100 (9:00 p.m.) on 9/26/2021, 9/27/2021, 9/28/2021, 9/29/2021 and 9/30/2021.  - "Alprazolam Tablet 0.5 mg Give 2 tablet by mouth two times a day for anxiety. Start Date:  09/24/2021 1700 (5:00 p.m.) D/C (discontinue) Date 09/29/2021 0808 (8:08 a.m.)." Administered at 0900 (9:00 a.m.) and 1700 (5:00 p.m.) on 9/25/2021, 9/26/2021, 9/27/2021 and 9/28/2021.  The eMAR documented Resident #153 receiving Alprazolam 0.5mg at 9:00 a.m., 5:00 p.m., and		bipolar disease (1) an region, stage 4 (2).  Resident #153's most data set), a quarterly (assessment reference Resident #153 as soo assessment for menta of 0 - 15, 12- being memaking daily decisions.  The physician order set documented in part the "Alprazolam Tablet 0 (two) tablet by mouth the Verbal. Order Date: 0 - "Alprazolam Tablet 0 mouth two times a day anxiety disorder, unspentered. Order Date:  The eMAR (electronic record) dated 9/1/2021 #153 documented in part the "Alprazolam Tablet 0 mouth two times a day Anxiety Disorder, unspended 19/25/2021, 9/27/2021, 9/30/2021.  "Alprazolam Tablet 0 mouth two times a day Anxiety Disorder, unspended 19/25/2021, 9/27/2021, 9/30/2021.  "Alprazolam Tablet 0 mouth two times a day 09/24/2021 1700 (5:00 Date 09/29/2021 0808 at 0900 (9:00 a.m.) and 9/25/2021, 9/26/2021, 1706 eMAR documented 19/25/2021, 9/26/2021, 1706 eMAR documented 19/25/2021, 9/26/2021, 1706 eMAR documented 19/25/2021 enter 19/25/2021, 9/26/2021, 1706 eMAR documented 19/25/2021 enter 19/25/2021, 9/26/2021, 1706 eMAR documented 19/25/2021 enter 19/25/2021, 9/26/2021, 1706 eMAR documented 19/25/2021 enter 19/25/2021 enter 19/25/2021, 9/26/2021, 1706 eMAR documented 19/25/2021 enter 19/2	recent MDS (minimum assessment with an ARD e date) of 9/13/2021, coded ring a 12 on the staff at status (BIMS) of a score oderately impaired for s.  ummary dated 9/29/2021 e following: .5 mg (milligram) Give 2 two times a day for anxiety. 9/24/2021." .5 mg Give 2 tablet by r for anxiety related to ecified. Prescriber 09/24/2021." medication administration 1-9/30/2021 for Resident art the following: .5 mg Give 2 tablet by r for anxiety related to becified. Start Date: .5 mg Give 2 tablet by r for anxiety related to becified. Start Date: .5 mg Give 2 tablet by r for anxiety related to becified. Start Date: .5 mg Give 2 tablet by r for anxiety. 9/29/2021 and .5 mg Give 2 tablet by r for anxiety. Start Date: .5 mg Give 2 tablet by r for anxiety related to r for anxiety. Start Date: .5 mg Give 2 tablet by r for anxiety related to r for anxiety related to r for anxiety related to r for anxiety related to r for anxiety related to r for anxiety related to r for anxiety related to r for anxiety related to r for anxiety related to r for anx	F	658					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A, BUILDING			PLETED
•		495227	B, WING				05/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER	· · ·	730	REET ADDRESS, CITY, STATE, ZIP CODE 10 FOREST AVE CHMOND, VA 23226		
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F 658	9:00 p.m. on 9/25/21, 9/28/21.  The progress notes in documented in part the register of a curinalysis with cultur uti (urinary tract infectored for her Xanax (to two tablet BID (twing faxed to the pharmach register). The controlled substance daily for chronic the controlled substance daily for chronic the controlled substance daily for chronic the controlled substance daily for chronic the controlled substance daily for chronic the controlled substance daily for chronic the comprehensive documented in part, MEDICATIONS: [Readverse effects relation medication, use of an Diagnosis of Bipolar resistant depression suddenly died Date in Revision on: 09/27/2 On 10/4/2021 at 10:: staff member) #2, the that the LPN (license worked the day shift 9/28/21 no longer worked).	or Resident #153 he following: l:54 p.m.) Note Text: order for a UA C and S he and sensitivity) to rule out stion) resident also has a new Alprazolam) to be changed ce a day) orders has been by." l:34 a.m.)She is on Xanax ce anxiety."  ance log for Resident #153 heart #153 on 9/25/21, heart #153 on 9/25/21, heart #153 is at risk for heart #153 is at risk for heart for Resident #153 heart #153 is at risk for heart for Resident #153 heart #153 is at risk for heart for Resident #153 heart #153 is at risk for heart for Resident #153 heart #153 is at risk for heart for Resident #153 heart #153 is at risk for heart for Resident #153 heart #153 is at risk for heart for Resident #153 heart #153 is at risk for heart for Resident #153 heart #153 is at risk for heart for Resident #153 heart #153 is at risk for heart for Resident #153 heart #153 is at risk for heart for Resident #153 heart #153 he		658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		495227	8. WING_		C 10/05		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	S, CITY, STATE, ZIP CODE		
WESTPOR	RT REHABILITATION ANI	LITATION AND NURSING CENTER 7300 FOREST AVE RICHMOND, VA 23226					
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(X5) COMPLETION OATE		
F 658	Continued From page conducted with LPN # LPN #10 stated that in the pharmacy and revidiscrepancies. LPN # also clarified any unus discrepancies with me physician. LPN #10 re (electronic medication Resident #153 dated stated that there was stated that there was Alprazolam on 9/26/25 LPN #10 stated that the order and disconting 9/29/2021. LPN #10 should have questione scheduled for Alprazolam scheduled for Alprazolam had change stated that they were a Alprazolam had change stated that they were a Alprazolam at 5:00 p.r. shift but now it was on reviewed the eMAR deand stated that Reside medication three times ordered twice a day be stated that they were and stated that Reside medication three times ordered twice a day be	149 10, the unit nurse manager, new orders were verified by riewed for any 10 stated that the nurses sual orders or any edications with the eviewed the eMAR administration record) for 9/1/2021-9/30/2021 and a duplicate order for 1, 9/27/21 and 9/28/21, omeone must have clarified nued the duplicate on stated that the day nurse ed the two 9:00 a.m. doses lam on 9/26/21, 9/27/21 and p.m., an interview was 11. LPN #11 stated that ng shift and had noticed or Resident #153's ged recently. LPN #11 administering the m. and 9:00 p.m. on their ly at 9:00 p.m. LPN #11 ated 9/1/2021-9/30/2021 ent #153 was getting the	Fe	658	· ·		A 8
	on clarifying the physic	ASM #2 for the facility policy cian orders. ASM #2 also used Lippincott as their	Value of the state				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION	C	(X3) DATE SURVEY COMPLETED	
		495227	B. WING				
	ROVIDER OR SUPPLIER	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	STATE, ZIP CODE		05/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
	documented in part, "A order should be clearly Cournadin change from be written as a) Increated aily or b) DC current of 3.0mg PO daily Transfollowing steps: a. Clarencessaryf. For a mechange, discontinue the DC'd and the date. A hefocus attention on the forder on the MAR/TAR According to "Fundame Lippincott, Williams and "After you receive a writranscribe it onto a worby your health care factorated and in the carefully, concentrate of check it when you're firm order duplications that receive a medication in On 10/4/2021 at approximation and ASM were made aware of the No further information with the control of the control	sing Policies and Documentation Orders" dated 8/19/08 Any change to a preexisting y stated in the order, e.g. a m 2.0mg to 3.0mg should se Coumadin to 3.0mg PO Coumadin order, Coumadin scribe the orders using the eify the order if edication/treatment order e previous entry by writing ighlighter may be used to change. Enter the new as appropriate"  entals of Nursing- d Wilkins 2007 page 169, itten medication order, king document approved illityread the order en copying it correctly, hished. Be sure to look for could cause your patient to error"  cimately 4:30 p.m., ASM mber) #1, the #2, the director of nursing e concern.  vas provided prior to exit.	F	658			

#### FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A. BUILDING \_ IDENTIFICATION NUMBER: C AND PLAN OF CORRECTION 10/05/2021 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 495227 7300 FOREST AVE NAME OF PROVIDER OR SUPPLIER RICHMOND, VA 23226 WESTPORT REHABILITATION AND NURSING CENTER (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX TAG F 658 Continued From page 151 F 658 the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-dis order/index.shtml. 2. Pressure ulcer: are also called bedsores, or pressure sores. They can form when your skin and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This pressure reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this area to become damaged or die. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0 00147.htm. 2. Resident #129 was admitted to the facility with diagnoses that included but were not limited to cerebral infarction (2) and end stage renal. disease (3). Resident #129's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/4/2021. coded Resident #129 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section M documented Resident #129 not having any pressure ulcers. The progress notes for Resident #129 documented in part the following: \*9/20/2021 06:08 (6:08 a.m.) Note Text: Dr. Breton -- MD (medical doctor) on call for [Name of physician] was contacted regarding pus-like discharge coming from resident's penis. MD stated that she will call back at around 7am." \*9/20/2021 07:49 (7:49 a.m.) Note Text: Penis is split and bleeding, has an area yellow and green

PRINTED: 10/19/2021

OFIAICI	COT OIL MEDIONILE G	INCOIONID OCITATOCO	_			CIVID IV	2. 0000 0001	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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		495227	B, WING			10/	05/2021	
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	to leave message, RF set up. Nurse informed will f/u (follow up) to come will f/u (follow up) to come will f/u (follow up) to come will f/u (follow up) to come will f/u (follow up) to come will f/u (follow up) to come drainage - called [Nandurology NP (nurse pramuch appreciate recome today (UA C+S (urinal sensitivity) ordered) - come dependent for the come will continue the come of the come of the come will be come to the come of the	called Resident RP lame of RP], and attempted P VM (voice mail) was not d desk nurse this shift who contacting the resident RP." 0 a.m.) note Purulent penile ne of urology practice] cititioner) for guidance- very mmendations - culture urine ysis with culture and start on cephalosporin 00mg (milligram) BID (twice d dosed) - start topical dered bactroban application are times a day) x 7 days) - (ordered voiding trial for n leave Foley (indwelling or 12 hours [sometimes are] for those on HD d assess for spontaneous providing trial with bladder sess residual volume within ag trial" 9 p.m.) Note Text: Resident had NP [nurse practitioner] regarding inflamed sore as for healing in the system attime." 1 a.m.) noteThe wound care NP 1. He is currently applying and taking cephalexin alture. He reports he is in at the Foley is out"  for Resident #129 1/23/2021 10:59 (10:59	F	658				
	documented in part, "9							

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/19/2021 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
	I AN OF CORRECTION I CONTRECATION NUMBER.					(	С	
		495227	B. WING			10/	05/2021	
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE			
WESTERS	RT REHABILITATION ANI	D MUDSING CENTER			7300 FOREST AVE			
WESTFOR	TI REMADILITATION AND	D WORDING CENTER			RICHMOND, VA 23226			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION DATE	
F 658	Continued From page	153	F	658	3			
	New, acquired in hous	se? Yes, Etiology- Pressure						
		nse wound with Normal						
	Saline"					•		
	dated 9/30/2021 failed	ummary for Resident #129 I to evidence an order for a sure ulcer to the posterior						
	record) dated 9/1/202 #129 documented Bac applied to the tip of the from 9/20/2021 throug and eTAR (electronic trecord) dated 9/1/202	e penis three times a day th 9/27/2021. The eMAR treatment administration 1-9/30/2021 failed to on of a treatment to the						
	dated 4/2/2021 docum alteration in skin integr chronic pressure ulcer incontinent episodes	s, med (medication) use, . Actual skin impairment as ior penisDate Initlated:						
	conducted with LPN (li wound care nurse. LP worked during the wee weekend and performe stated that they rounde nurse practitioner where assess wounds. LPN was evidenced by doctreatment administration that they were aware they	ekdays and every other ed the wound care. LPN #4 ed with the wound care in they came every week to #4 stated that wound care		100				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		LE CONSTRUCTION		(X3) DATE COMP	SURVEY
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NAME OF D	DOMBER OF CHOOLIES	453221	10,		PARCET ADDRESS OFFI STATE HIS CODE		1 10/	05/2021
NAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE			
WESTPO	RT REHABILITATION AND	NURSING CENTER	7300 FOREST AVE					
				<u> </u>	RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE					(XS) COMPLETION DATE
F 658	not in the physician or they had rounded with knew that was the treafor the area so she cle was working. LPN #4 would not know to conthere was no order in without an order for the documentation of treat could not evidence that done since 9/27/2021.  On 10/5/2021 at approrequest was made to Amember) #2, the direct policy on transcribing of the facility policy "Nur Procedures: Physician Medication/Treatment documented in part, "In medication/treatment resident's medical rect signature of the person order. The order is recorder sheet or the telep verbal order Transcrib Treatment Administrative lements of the order and continuation of the order and continuati	armal saline, however it was ders. LPN #4 stated that the nurse practitioner and atment that she had ordered transport that she had ordered transport that she had ordered transport that she had ordered transport that she stated that other staff inplete the care because place. LPN #4 stated that the treatment and without transport that the treatment and without transport that the state that the treatment had been eximately 9:15 a.m., a asset (administrative staff for of nursing for the facility orders.  Sing Policy and Documentation Orders" dated 8/19/08 a.Each order is documented in the order with the date, time and a writing or receiving the orded on the physician other order sheet if it is a per treatment order on the on Record, including all the and the date"		658				
	were made aware of the	e concern. was provided prior to exit.						
	References:							

PRINTED: 10/19/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING 495227 B. WING 10/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE WESTPORT REHABILITATION AND NURSING CENTER RICHMOND, VA 23226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 658 Continued From page 155 F 658 1. Pressure ulcer: are also called bedsores, or pressure sores. They can form when your skin and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This pressure reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this area to become damaged or die. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0 00147.htm. 2. Cerebrovascular disease, infarction or accident: A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm. 3. End-stage kidney disease: The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm. F 684 Quality of Care F 684 1. Residents #153 and #82 SS=E | CFR(s): 483,25 remain in center weights obtained for month of § 483.25 Quality of care October. Resident #433 no Quality of care is a fundamental principle that longer remains in center. applies to all treatment and care provided to 2. Review of all current facility residents. Based on the comprehensive residents MAR/TAR from assessment of a resident, the facility must ensure 09/01/2021 to current to that residents receive treatment and care in ensure execution of physician accordance with professional standards of orders. practice, the comprehensive person-centered

PRINTED: 10/19/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495227 B. WING 10/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE WESTPORT REHABILITATION AND NURSING CENTER RICHMOND, VA 23226 {X4} ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD RE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 684 Continued From page 156 F 684 3. DON or designee will care plan, and the residents' choices. educate all facility nursing staff This REQUIREMENT is not met as evidenced to review policy on following physician orders to include Based on resident interview, staff interview. documentation requirements. facility document review and clinical record review 4. DON or designee will audit it was determined the facility staff failed to ensure 10% of all resident's MAR/TAR the weights were monitored per the weekly times 4 weeks and comprehensive person-centered plan of care for monthly times 2 to ensure two of 84 residents in the survey sample, facility fulfills physician orders. (Resident #153 and Resident #82); and failed to Any identified issues will be ensure physician ordered wound treatments were immediately corrected. Results provided as ordered for one of 84 residents in the will be reported to Quality survey sample, (Resident #433). Assurance committee for analysis and revision x 3 1. Resident #153 was identified as being at risk months. nutritionally with interventions to obtain weights, 5. Date of compliance will be monitor for weight loss and report significant weight loss, and had not been weighed since 3/6/21. 11/9/2 2. Resident #82 was assessed and identified as being at risk nutritionally with interventions to obtain weights, monitor for weight loss and report significant weight loss and had not been weighed since 5/8/21. 3. The facility staff failed to provide the physician ordered treatments to Resident #433's left hip surgical wound on multiple dates during April and May 2021. The findings include: 1. Resident #153 was admitted to the facility with diagnoses that included but were not limited to bipolar disease (1) and pressure ulcer of sacral region, stage 4 (2).

Resident #153's most recent MDS (minimum

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A, BUILDIN		AULTIPLE CONSTRUCTION ILDING			(X3) DATE SURVEY COMPLETED	
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	(assessment reference Resident #153 as soon assessment for mentary of 0 - 15, 12- being more making daily decisions Resident #153 as receivable a resident and regain in the assessment On 9/28/2021 at approximate was conduct Resident #153 stated weighed since they we and were not sure if the weight. Resident #153 refused for staff to weight asked for them to The comprehensive cardocumented in part, "Nesident #153] is at not increased metabolic dw/ (with) quadriplegia (stage 4 on sacrumD& Revision on: 09/27/202 "Interventions/Tasks" if "Obtain weights as ord loss and weight change 02/17/2021"  The weight summary for documented the most of 3/26/2021 with Resident pounds.  The physician order su	assessment with an ARD e date) of 9/13/2021, coded ring a 12 on the staff il status (BIMS) of a score oderately impaired for s. Section K coded siving a therapeutic diet ot having a weight loss or at period.  eximately 3:37 p.m., an ed with Resident #153. that they had not been are admitted to the facility ey had lost or gained a stated that they never gh them but at times they come back later.  are plan for Resident #153 JUTRITION: [Name of atritional risk r/t (related to) armands of wound healing, 3), PU (pressure ulcer) ate Initiated: 02/17/2021, 21." Under a documented in part, ered, monitor for weight es, Date Initiated:  or Resident #153 recent weight obtained on	F	684				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COME	SURVEY PLETED	
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F 684	Continued From page	: 158	F	684				
		Resident #153 failed to ion of resident refusals of						
	2/15/2021 for Resider "Spoke to resident v dislikes food provided out food for all meals, what is provided. Obte preferences, kitchen of resident on how to cal Denies issues chewin constipation or diarrhed diet as ordered: regula ordered, monitor for w changes. Provide food The progress notes fo documented in part, "5	nade aware. Instructed I kitchen and request items. g/swallowing, n/v, ea. Recommend provide ar. Obtain weights as reight loss and weight I preferences as desired"  r Resident #153 0/16/2021 12:37						
	weight. Last weight: 19 increased due to wour (recommendations) Cocarbohydrate] diet for supplements for woun changes and update Polinically indicated."  On 9/30/2021 at 1:10 gooducted with LPN (II #10, the unit nurse mathat residents were we weights were document #10 stated that if a resweighed they notified to responsible party. LPI	c.m., an interview was censed practical nurse) nager. LPN #10 stated eighed monthly and the nted in the computer. LPN ident refused to be						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 684	there should be progreefusals in the medical on 10/4/2021 at 10:37 conducted with OSM dietician. OSM #8 staresidents in the facility for any significant gair stated that they were a Resident #153 refused encouraged them to dimedical record. OSM #153 was at risk for nubecause of the pressure weight documentation would prefer to have a Resident #153.	ess notes documenting the li record.  7 a.m., an interview was (other staff member) #8, ited that they tracked all the vand monitored the weights as or losses. OSM #8 advised by staff that di their weights and they ocument the refusals in the #8 stated that Resident utritional deficiencies re ulcer and the sporadic. OSM #8 stated that they current weight to monitor	F	684				
	conducted with LPN # weights were monitore month unless they wer LPN #8 stated that resulcers required monito being more high risk. residents refused to be documented in the proof The facility policy "Wei 10/17/2018 documented are weighed a minimum of each month with moobtained as ordered or Weights are verified ar	of for residents every the ordered more frequently. Idents who had pressure ring of weights due to LPN #8 stated that when the weighed they gress notes.  Ight Management" dated and in part, "4. Residents and of monthly, by the 10th the frequent weights and documented in the the are obtainedThe entire must be involved in the to manage the ordered member					Ð1.€	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT	TIPLE CON		(X3) DATE SURVEY COMPLETED	
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F 684	(administrative staff m administrator and ASM were made aware of the No further information References:  1. Bipolar disorder: (formanic-depressive illne a mental disorder that mood, energy, activity the ability to carry out information is taken from	eximately 4:30 p.m., ASM ember) #1, the M #2, the director of nursing the concern.  was provided prior to exit.  eximately 4:30 p.m., ASM embers in the director of nursing the concern.  was provided prior to exit.  eximately 4:30 p.m., ASM embers in the website	F6	684			
	order/index.shtml.  2. Pressure utcer: is a breaks down when sor pressing against the signouped by the severit the mildest stage. Stag A reddened, painful and turn white when pressure utcer is forming or cool, firm or soft. Stag forms an open sore. The may be red and irritate develops an open, sun The tissue below the side able to see body fat The pressure utcer has there is damage to the sometimes to tendons information was obtain.	mething keeps rubbing or kin. Pressure sores are y of symptoms. Stage I is ge IV is the worst. Stage I: ea on the skin that does not ed. This is a sign that a ng. The skin may be warm age II: The skin blisters or ne area around the sore d. Stage III: The skin now ken hole called a crater. kin is damaged. You may in the crater. Stage IV: become so deep that muscle and bone, and and joints. This					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILDIN	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226	ODE		
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	function in part of your something goes wrong pass between your brocan be complete or pass between your brocan be complete or pass between your brocan be complete or pass between your brocan be complete or pass between your localled paraplegia. Part is quadriplegia. This is the website https://medlineplus.gor  2. Resident #82 was a diagnoses that include hemiplegia (1) and cer resident #82's most reset), an annual assess (assessment reference Resident #82 as scoring assessment for mental of 0 - 15, 2- being severally decisions. Section receiving tube feeding white a resident at the the comprehensive cardocumented in part, "A risk r/t (related to) poor need for enteral feeds.	alysis is the loss of muscle r body. It happens when g with the way messages ain and muscles. Paralysis artial. It can occur on one or ly. It can also occur in just widespread. Paralysis of body, including both legs, is alysis of the arms and legs information is taken from cyparalysis.html.  admitted to the facility with do but were not limited to rebral infarction (2).  accent MDS (minimum data ment with an ARD e date) of 8/11/2021, coded in a status (BIMS) of a score erely impaired for making in K coded Resident #82 as and a therapeutic diet facility.  are plan for Resident #82 at potential for nutritional po (by mouth) intake andDate Initiated: in: 04/15/2021." Under documented in part, esponsible party of ges, Date Initiated: hts as ordered, Date	F6	84	2640 26		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/19/2021 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			
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l	PROVIDER OR SUPPLIER			S1 73	REET ADORESS, 800 FOREST AVE		CODE	) 10	0/05/2021
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	complications of feeding aspiration potential, so (due to) CVA (stroke). Supplemental nutrition regular po (by mouth) head of bed in flat pos 11/21/2020. Revision "Interventions/Tasks" if "Monitor weights and reposed to AFib (3)Da Revision on: 06/10/2020 "Interventions/Tasks" if "Obtain weights as indisignificant changes, Da The weight summary for documented the most resident #82.  The physician order surfailed to evidence an order Resident #82.  The clinical record for Fevidence documentatio weight monitoring.	or feeding tube/potential for any tube use related to vallowing impairment d/t Feeding tube used for and for flushes. Tolerating diet Resident will put her ition, Date Initiated; on 11/21/2020." Under the documented in part, eport significant changes, 020" The care plan for anted, "Cardiac disease the Initiated: 11/07/2019, 20." Under the documented in part, icated and report ate Initiated: 02/20/2020"  The Resident #82 recent weight obtained on #82 weighing 155 pounds.  Immary dated 10/1/2021 resident #82 failed to an of resident refusals of the resident refusals of the resident refusals of the Resident ref	F	684					
c	On 9/30/2021 at 1:10 p. conducted with LPN (lic #10, the unit nurse man	ensed practical nurse)							

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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ŀ	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1 10	10512021	
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	weights were docume #10 stated that if a res weighed they notified responsible party. LP #82 received tube feet monitor for weight chat they did not know why documented after May On 10/4/2021 at 10:37 conducted with OSM (dietician. OSM #8 staresidents in the facility for any significant gain stated that Resident #boluses and water flus tube and also ate by mesident #82's clinical weights had dropped of #8 stated that according weight in May, Resident weight in May, Resident weight in May, Resident to see documentation to see documentation of than May of 2021. Os advise the staff to documedical record.  On 10/4/2021 at 11:36 conducted with LPN #8 weights were monitorer month unless they were LPN #8 stated that resifieding required monitobeing more high risk fo stated that when reside they documented in the	eighed monthly and the need in the computer. LPN ident refused to be the physician and the N #10 stated that Resident ding and was important to inges. LPN #10 stated that there were no weights 2021.  If a.m., an interview was other staff member) #8, ted that they tracked all the and monitored the weights sor losses. OSM #8 82 received tube feeding thes through their feeding touth. OSM #8 reviewed record and stated that the off after May of 2021. OSM and they would prefer the stated that they feeds but they would prefer they would prefer they was stated that they ment any refusals in the a.m., an interview was a.m., and an interview was a.m., and an interview was a.m., an interview was a.m., and an interview was a.m., and an interview was a.m., and an interview was a.m., and an interview was a.	F 68				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. SUILO		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
•	were made aware of the No further information References:  1. Hemiplegia: also can Quadriplegia. Paralys function in part of your something goes wrong pass between your bracan be complete or paraboth sides of your bod one area, or it can be information was obtain https://medlineplus.gov.  2. Cerebrovascular disaccident: A stroke. With the brain stops. A strok "brain attack." If blood than a few seconds, the nutrients and oxygen. I lasting damage. This inform the website: https://medlineplus.gov.  3. Atrial fibrillation: a prhythm of the heartbear obtained from the website website in the website of the property of the heartbear obtained from the website in the website obtained from the website obtained from the website in the property of the heartbear obtained from the website in the property of the heartbear obtained from the website.	ember) #1, the  #1 #2, the director of nursing he concern.  was provided prior to exit.  #1 #2 #3 #4 #4 #4 #4 #4 #4 #4 #4 #4 #4 #4 #4 #4	F	684			

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/19/2021 FORM APPROVED

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 684	Continued From page (progressive state of near Parkinson's disease (progressive state of near Parkinson's disease (progressive the progression of poor nutred pression and decreate leading to a downward.  The most recent MDS assessment, a five day with an ARD (assessment, a fore day with an ARD (assessment) and progression indicating the result of the BIMS (brief is score, indicating the recognitively impaired. A G-functional status code requiring extensive asstransfer, locomotion, extended and progression M-Skin Composition of the progression M-Skin Composition of the progression of Resident #40 plan dated 5/3/21, document of the progression of the procurs of the progression of the procurs of the procu	nental decline) (2), progressive neurological I by resting tremor) (3) and multiple chronic medical rition, weight loss, inactivity, asing functional ability I spiral). (4)  (minimum data set) / Medicare assessment rent reference date) of rident as scoring a 06 out of nterview for mental status) sident is severely review of the MDS Section red Resident #433 as ristance for bed mobility, rating, dressing; total re / bathing and walking did MDS Section H- bowel and rit #433 as always rid for bladder. A review of ronditions- coded the reable deep tissue injury resident in part, kin integrity related to		684			ALC.		
l v	wound care is document separate tracking sheet						en en en en en en en en en en en en en e		
/	a review of the physicia	n orders dated 4/24/21,					- {	I	

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
1		495227	B. WING			C 40/05/2024	
	PROVIDER OR SUPPLIER	NURSING CENTER	73	REET ADDRESS, CITY, STATE, ZIP CODE 00 FOREST AVE CHMOND, VA 23226	1 10/	05/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(XS) COMPLETION DATE	
	site with saline and ap dressing daily as need shift."  A review of the wound documented in part, "L wound."  A review of Resident # administration record] evidence wound care with doctor to the reside on the following dates: day shift."  A review of Resident # failed to evidence wourd care wound care with doctor to the reside on the following dates: day shift."  A review of Resident # failed to evidence wourd ordered by the doctor to surgical wound on the foon 5/9 and 5/24 day shift.  On 10/04/21 at 11:38 A conducted with LPN (lick the propossible for complete stated, "Wound nurses Friday. Our scheduler I covering or if the nurses treatment. If something the floor nurse does the are documented on the TAF Con 10/4/21 at 12:20 PM conducted with LPN #2, asked who was response.	LEFT HIP: Cleanse surgical ply island-bordered gauze led if solled AND every day care notes dated 4/26/21, left hip-etiology surgical 433's TAR [treatment for April 2021, failed to was provided as ordered by ents left hip surgical wound "Left hip on 4/24 and 4/25 433's TAR for May 2021, and care was provided as the residents left hip following dates: "Left hip infit."  M an interview was leensed practical nurse) #8, an asked who was in asked who was in someone is someone is someone to do their own is ordered twice a day be treatment. Treatments TAR; refusals are R."	F 684				
	#2 stated, "The wound on nurse on the medication	care nurse or the staff cart." When asked what					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING \_\_\_\_\_\_

			A. BUILDING				
		495227	B. WING			C 10/05/2021	
	PROVIDER OR SUPPLIER RT REHABILITATION AN	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	IEFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECT CROSS-REFERENCE	LAN OF CORRECTION TVE ACTION SHOULD BE SED TO THE APPROPRIATE FICIENCY)	(XS) COMPLETIO DATE	
	blanks on the TAR memeans that it wasn't done of the means that it wasn't done of the means that it wasn't done of the member of the member of the nursing stated, "Lipping edition, Wolters Kluwer practice."  On 10/4/21 at 4:50 PM member) #1, the admidirector of nursing well director of nursing well findings.  According to the nursing deviation from protocount the patient's chart with of the nurse's decision for the care provided, it deviation. This should care is rendered becaused to a less than accompedition of the care provided, it is should care is rendered becaused to a less than accompedition of the care provided, it is should care is rendered becaused to a less than accompedition of the care provided, it is should care is rendered becaused to a less than accompedition of the care provided, it is should care in the member of the nurse of the nurs	ean, LPN #2 stated, "It lone."  mately 11:00 AM, ASM lember) #2, the director of local to the country in the co	F 684		Mol	SE EN	

PRINTED: 10/19/2021 FORM APPROVED

OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED

MME OF PROVIDER OR SUPPLIER  WESTPORT REHABILITATION AND NURSING CENTER  RICHMOND, VA. 23225  STREET ADDRESS, CITY, STATE, ZIP CODE TOP FOREST AVE RICHMOND, VA. 23225  STREET ADDRESS, CITY, STATE, ZIP CODE TOP FOREST AVE RICHMOND, VA. 23225  PREPRIX TAG  FOR PROVIDER OR SUPPLIER  EACH DEPERCIEW MUST ER PRECEDED BY PILL, REGULATORY OR LISC IDENT PYING INFORMATION)  FOR SEASON, AND A STATE LIST OF CODE STREET TAG  FOR SEASON, AND A STATE LIST OF CODE STATE TAG  FOR STREET ADDRESS, CITY, STATE, ZIP CODE TOP FOREST AVE RICHMOND, VA. 23225  PREPRIX TAG  FROM CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPERCIENCY  PREPRIX TAG  FOR STREET ADDRESS, CITY, STATE, ZIP CODE TOP FOREST AVE RICHMOND, VA. 23225  PROVIDER TAG  PROVIDER OF A STATE REGULATORY OR LIST OF STATE TAG  PREPRIX TAG  FROM CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPERCY TAG  FOR STATE REGULATORY OR LIST OF STATE TAG  FROM CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPERCY TAG  FROM CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPARTMENT OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPARTMENT OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPARTMENT OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPARTMENT OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPARTMENT OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPARTMENT OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPARTMENT OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPARTMENT OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPARTMENT OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPARTMENT OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPARTMENT OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPARTMENT OF CORRECTION SHOULD SHO		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
WESTPORT REHABILITATION AND NURSING CENTER  WESTPORT REHABILITATION AND NURSING CENTER  RECULATORY OR LSC DENT TYME REPORTED BY FULL, RECULATORY OR LSC DENT TYME REPORTED BY FULL, RECULATORY OR LSC DENT TYME REPORTED BY FULL, RECULATORY OR LSC DENT TYME REPORTED BY FULL, RECULATORY OR LSC DENT TYME REPORTED BY FULL, RECULATORY OR LSC DENT TYME REPORTED BY FULL, RECULATORY OR LSC DENT TYME REPORTED BY FULL, RECULATORY OR LSC DENT TYME REPORTED BY FULL, RECULATORY OR LSC DENT TYME REPORTED BY FULL, RECULATORY OR LSC DENT TYME REPORTED BY FULL, RECULATORY OR LSC DENT TYME REPORTED BY FULL, RECULATORY OR LSC DENT TYME REPORTED BY FULL, RECULATORY OR LSC DENT TYME REPORTED BY FULL, RECULATORY OR LSC DENT TYME REPORTED BY FULL, RECULATORY OR LSC DENT TYME REPORTED BY FULL, RECULATORY OR LSC DENT TYME REPORTED BY FULL, RESIDENT BY A LSC DENT TYME RECULATORY OR LSC			495227	B. WING_		•
WESTPORT REHABILITATION AND NURSING CENTER  7369 FOREST AVE RICHMOND, VA. 22226  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FILL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FILL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FILL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FILL TAG (EACH DEFICIENCY)  F 684  Continued From page 168 Chapman, page 213/345. (7) Lippincott Nursing Practice, 11th edition, Wolters Kluwer, page 15. Treatment/Svocs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b) Skin Integrity \$483.25	NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS CITY STATE 710 CODE	10/05/2021
FREFIX TAG  FOR THE RECULATORY OR LSC IDENTIFYING INFORMATION)  FOR A Continued From page 168 Chapman, page 213/345. (7) Lippincott Nursing Practice, 11th edition, Wolters Kluwer, page 15. FOR Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(0)(ii)  S483.25(b)(1) Fressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:  Based on staff interview, resident interview, clinical record review, facility document review and in the course of a complaint investigation the facility staff falled to provide the necessary treatment and services, to promote healing of a pressure ulcer for five of 84 residents in the survey sample, Resident #433, Resident #122, Resident #422, Resident #433, Resident #422, Resident #433, Resident #422, Resident #424, Resident #433, Resident #424, Resident #433, Resident #424, Resident #433, Resident #424, Resident #433, Resident #424, Resident #433, Resident #424, Resident #433, Resident #424, Resident #433, Resident #424, Resident #433, Resident #433, Resident #424, Resident #434, Resident #433, Resident #424, Resident #433, Resident #424, Resident #434, Resident #433, Resident #434, Resident	WESTPO	RT REHABILITATION AND	NURSING CENTER		7300 FOREST AVE	
Chapman, page 213/345.  (7) Lippincott Nursing Practice, 11th edition, Wolters Kluwer, page 15.  F 686 SS=E CFR(s): 483.25(b)(1)(jiii)  \$483.25(b) Skin Integrity \$483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers unless the Individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives eare, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.  This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and in the course of a complaint investigation the facility staff failed to provide the necessary treatment and services, to promote healing of a pressure ulcer for five of 84 residents in the survey sample, Resident #433's sacral pressure injury on multiple dates during April and May 2021.  1. Residents # 433, #142 and #129 no longer reside in center. Residents # 433, #142 and #129 no longer reside in center. Residents # 433, #142 and #129 no longer reside in center. Residents # 433, #142 and #129 no longer reside in center. Residents # 433, #142 and #159 remain in center, provider notified of missed treatments.  2. All current residents with pressure ulcers were audited on 11/01/2021 to ensure completion of wound care treatments.  3. DON or designee will provide facility nursing staff with education on policy regarding completion of wound care to include documentation.  4. DON or designee will audit 10% of all residents with current wounds to ensure completion of wound care to include documentation.  4. DON or designee will audit 10% of all residents with current wounds to ensure completion of wound care to include documentation.  5. Date of compliance will be investigation the facility staff failed to provide the physician ordered treatments to Resident #433's sacral pr	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	E COMPLETION
Chapman, page 213/345.  (7) Lippincott Nursing Practice, 11th edition, Wolters Kluwer, page 15.  F 686 SS=E  SS=E  F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(0)(ii)  \$483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (1) A resident receives care, consistent with professional standards of practice, to prevent ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and in the course of a complaint investigation the facility staff failed to provide the encessary treatment and services, to promote healing of a pressure ulcer for five of 84 residents in the survey sample, Resident #433's sacral pressure injury on multiple dates during April and May 2021.  1. Residents # 433, #142 and #129 no longer reside in center. Residents #23, and #153 remain in center, provider notified of missed treatments.  2. All current residents with pressure ulcers were audited on 11/01/2021 to ensure completion of wound care treatments.  3. DON or designee will provide facility nursing staff with education on policy regarding completion of wound care to include documentation.  4. DON or designee will audit 10% of all residents with current wounds to ensure completion of wound care to include documentation.  4. DON or designee will audit 10% of all residents with current wounds to ensure completion of wound care.  5. Do or designee will audit 10% of all residents with current wounds to ensure completion of wound care to include documentation.  6. DON or designee will audit 10% of all residents with current residents weekly times 2 to ensure that the facility is providing necessary w	F 684	Continued From page	168	F 6	84	
SS=E  CFR(s): 483.25(b)(1)(i)(ii)  §483.25(b) Skin Integrity §483.25(b) (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.  This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, and in the course of a complaint investigation the facility staff failed to provide the necessary treatment and services, to promote healing of a pressure ulcer for five of 84 residents in the survey sample, Resident #433, Resident #142, Resident #22, Resident #433, Resident #142, Resident #22, Resident #433's sacral pressure injury on multiple dates during April and May 2021.  2. The facility staff failed to provide the physician	F 686	(7) Lippincott Nursing Wolters Kluwer, page	Practice, 11th edition,			120
\$483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.  This REQUIREMENT is not met as evidenced by:  Based on staff interview, resident interview, clinical record review, facility document review and in the course of a complaint investigation the facility staff failed to provide the necessary treatment and services, to promote healing of a pressure ulcer for five of 84 residents in the survey sample, Resident #433, Resident #129.  1. The facility staff failed to provide the physician ordered freatments to Resident #33's sacral pressure injury on multiple dates during April and May 2021.		CFR(s): 483.25(b)(1)(i	)(ii)	10	no longer reside in center.	4
ordered treatments to Resident #142's left lateral		§483.25(b)(1) Pressure Based on the comprehersident, the facility mu (i) A resident receives professional standards pressure ulcers and do ulcers unless the individemonstrates that they (ii) A resident with pressure treatment are with professional stand promote heating, prevenew ulcers from develoing the record review, facility staff failed to professional stand promote heating the record review, facility staff failed to professional stand in the course of a carried ment and services, pressure ulcer for five of survey sample, Resident #22, Resident 1. The facility staff failed ordered treatments to Repressure injury on multiplications. The facility staff failed ordered treatments to Repressure injury on multiplications. The facility staff failed ordered treatments to Repressure injury on multiplications.	ensive assessment of a lest ensure that- care, consistent with of practice, to prevent less not develop pressure dual's clinical condition less were unavoidable; and sure ulcers receives and services, consistent less of practice, to not infection and prevent ping. In some that evidence were unavoidable; and services, consistent less of practice, to not infection and prevent ping. In some that evidence were less evidence development investigation the less evident les evident less evident les evident l		center, provider notified of miss treatments.  2. All current residents with pressure ulcers were audited or 11/01/2021 to ensure completion wound care treatments.  3. DON or designee will provide facility nursing staff with education policy regarding completion wound care to include documentation.  4. DON or designee will audit 10 of all residents with current wout to ensure completion of wound treatments weekly times 4 week and monthly times 2 to ensure the facility is providing necessar wound care. Any identified issue will be immediately corrected. Results will be reported to Quali Assurance committee for analys and revision x 3 months.	ed  n n of  on of  0%  nds  s hat y es  ty is
		<ol> <li>The facility staff failed ordered treatments to R</li> </ol>	to provide the physician esident #142's left lateral			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B, WING			C 10/05/2021	
NAME OF F	PROVIDER OR SUPPLIER		<del>'</del>	STREET ADDRESS, CITY, STATE, ZIP COD		0/03/2021	
WESTPO	RT REHABILITATION AN	NURSING CENTER		7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 686	Continued From page	169	F 68	86			
		v (stage), sacral (stage) and stage it is) pressure injuries ng September 2021.					
	ordered treatments for	ed to provide physician Resident #22's pressure les in July 2021, August 2021.					
	ordered by the physici August 2021 and Sept	ed to provide treatments as an on multiple dates in ember 2021, to promote alcer (1) for Resident #153.					
1	5. The facility staff fail telephone order for pre resulting in a failure to promote healing of Res (1).	essure ulcer treatment		174	27		
	The findings include:	≝ .	22				
	4/23/21 with diagnoses limited to: left total hip replacement of the hip (progressive state of m Parkinson's disease (pi disorder characterized adult failure to thrive (m	joint) (1), dementia ental decline) (2), rogressive neurological by resting tremor) (3) and nultiple chronic medical tion, weight loss, inactivity, sing functional ability					
		Medicare assessment					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B, WING			C 10/05/2021	
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 107	UJIZUZ I	
WESTPO	RT REHABILITATION AND	NURSING CENTER		) FOREST AVE HMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE	
	G-functional status correquiring extensive as transfer, locomotion, edependence for hygier not occur. A review of bladder coded Resider incontinent for bowel at MDS Section M-Skin Cresident with an unstagand surgical wound.  A review of Resident #plan dated 5/3/21, doc "FOCUS-Alteration in simpaired mobility weak INTERVENTIONS-ObsADL (activities of daily abnormalities."  The medical record for pressure ulcer care do no separate pressure ulcer care documented in part, "Swound with saline, applemollient) (5) and then (hemostatic) (6). Cover dressing as needed for shift for wound."  A review of the wound of documented in part, "Saulcer suspected deep time a review of Resident #4 review of Resident #4 review of Resident #4 review of Resident #4	esident is severely A review of the MDS Section ded Resident #433 as sistance for bed mobility, aating, dressing; total ne / bathing and walking did MDS Section H- bowel and nt #433 as always and for bladder. A review of Conditions- coded the geable deep tissue injury  433's comprehensive care uments in part, skin integrity related to mess and incontinent. serve skin condition with living) care daily and report  Resident #433, revealed cumented on the TAR, with alcer tracking sheet.  an orders dated 4/24/21, acral wound: cleanse by medihoney (wound calcium alginate with a boarder foam if soiled AND every day  care notes dated 4/26/21, acrum-etiology is pressure ssue injury."	F 686				
	administration record] for	or April 2021, talled to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		C 10/05/2021	
NAME OF PROVIDER WESTPORT REHA		NURSING CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
eviden the phy 4/26 da  A revie failed to ordered "Sacrun  On 10/6 conduct the unit respons stated, Friday. coverin treatme the floo are doc docume  On 10/4 conduct asked w #2 state nurse on blanks of means t  On 9/30 (adminis nursing edition, practice.  On 10/4 member	ysician on the force yshift."  It wo of Resident # o evidence would by the physician on 5/9, 5/24 at 04/21 at 11:38 / otted with LPN (lift manager. Whosible for comple "Wound nurses Our scheduler go or if the nurse does the unented on the Earth of the transport of the transport of the transport of the transport of the transport of the TAR meanth of the	was provided as ordered by billowing dates: "Sacrum on 2433's TAR for May 2021, and care was provided as an on the following dates: and 5/26 day shift."  AM an interview was censed practical nurse) #8, an asked who was ting wound care, LPN #8 here Monday through lets us know if someone is as need to do their own g is ordered twice a day, a treatment. Treatments a TAR; refusals are R."  All and interview was and interview was and interview was and interview was and interview was and interview or the staff or cart." When asked what an, LPN #2 stated, "It	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
1		495227	B, WING		C
NAME OF F	PROVIDER OR SUPPLIER	104481		STREET ADDRESS, CITY, STATE, ZIP CODE	10/05/2021
WESTPORT REHABILITATION AND NURSING CENTER				7300 FOREST AVE RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 686	Continued From page 172		F 68	36	
	The facility policy, "Pressure Injury and Wound Management" dated 2/15, documented in part, "Any resident with a pressure injury or wound will receive treatment and services consistent with accepted standards of practice."				
	According to the nursing standard of practice, "A deviation from protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions and actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events." (7)				
	- 1	was provided prior to exit.		4	.
**	Complaint deficiency	92 98	* *	*.	
-	References:				
	Non-Medical Reader, 7 Chapman, page 271. (2) Barron's Dictionary Non-Medical Reader, 7 Chapman, page 154. (3) Barron's Dictionary Non-Medical Reader, 7 Chapman, page 435. (4) Barron's Dictionary	g Guide for Nurses, 36. g Guide for Nurses,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTR	RUCTION	(X3) DATE COMP	
		495227	B. WING		<del></del>		>
NAME OF D	ROVIDER OR SUPPLIER	493221	B. 111110			10/0	05/2021
THAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
WESTPO	RT REHABILITATION ANI	NURSING CENTER		7300 FOR	EST AVE		
				RICHMO	ND, VA 23226		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI: TAG	×	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETION
F 686	Continued From page	173					
	page		rt	886			
	(7) Lippincott Nursing Wolters Kluwer, page					İ	
	wollers Kluwer, page	15,					
	2 The facility staff faile	ed to follow the physician					
	ordered treatments to	Resident #142's left lateral					
	foot (stage 2) right elf	ow (stage 3), sacral (stage					
	4) and left lateral heel	(stage 2) pressure injuries					
	on multiple dates durir	a September 2021	1			ľ	
		<b>9 ,</b>					
	The medical record for	Resident #142, evidences		84			
		documented on the TAR,					
	with no separate press	sure ulcer tracking sheet.					
	Resident #142 was ad	mitted to the facility on					
	9/3/21 with diagnoses	that included but were not					
	limited to: sepsis (life-ti	hreatening organ					
	dysfunction caused by	response to a severe					
-	infection) (1), respirato	ry failure (inability of the	40	1	39		20
		ntain an adequate level of	12	8			
		diabetes mellitus (inability			•		
1	of insulin to function no	rmally in the body) (3).					
	The most recent MDS	(minimum data set)		9			
		Medicare assessment				ļ	
- 1	with an ARD (assessme	ent reference date) of				İ	
		#142 as scoring a 15 out				İ	
	of 15 on the BIMS (brie						
		the resident is cognitively					
		MDS Section G-functional		1		1	
		nt as requiring extensive		1			
	assistance for bed mob						
	dependence for locomo						
		not occur. A review of					
	MDS Section H- bowel						
	•	or bowel and indwelling					
		review of MDS Section K-		1			
		'yes', Section O- oxygen	Ì				
		oning all coded as 'yes'.					
KM CMS-2567(	02-99) Previous Versions Obsole	le Event IO: JFVL11		Facility ID: VAI	0270 If continu	ation sheet Par	no 174 of 264

STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED  C 10/05/2021	
		495227	B. WING					
1		D NURSING CENTER	. <b> J</b>	73	REET ADDRESS, CITY, STATE, ZIP CODE 00 FOREST AVE CHMOND, VA 23226		1 10,	03/2021
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	PORT REHABILITATION AND NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	686				
	evidence documentatio ordered wound care do	n that the physician						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  WESTPORT REHABILITATION AND NURSING CENTER			7300 FC	ADDRESS, CITY, STA PREST AVE OND, VA 23226	TE, ZIP CODE			
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	day shift, 9/17 day shift day shift. Right elbow: on 9/7 day shift and 9/26 day Sacrum on: 9/5 evening day shift and evening: day shift and evening: day shift and 9/26 day Left heel on: 9/7 day shift and 9/26 day shift, 9/25 day shift. An interview was cond PM with LPN (licensed wound care nurse. Wiresponsible for perform stated, "I'm here 4 day weekend, then agency the medication cart tak dressing change. I do evening nurse does it is asked how staff evident treatments was done, I the MAR/TAR (medication to the TAR, then it we can evidence that tredocument any refusal into ton the TAR, then it we can evidence that tredocumented."  An interview was condumented."  An interview was condumented."  An interview was condumented."  An interview was condumented."	ing dates: 7 day shift (7am-3pm), 9/11 ft, 9/25 day shift and 9/26 ry shift, 9/11 day shift, 9/17 shift. rg shift (3pm-11pm), 9/7 shift, 9/11 day shift, 9/17 shift. rg shift (3pm-11pm), 9/7 shift. rg sh	F	686				

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495227 B. WING 10/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE WESTPORT REHABILITATION AND NURSING CENTER RICHMOND, VA 23226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 686 Continued From page 176 F 686 always means it wasn't done, it could mean they were out of the room or refused." On 10/4/21 at 4:50 PM, ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above findings. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 524. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 502. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 160. (4) 2019 Lippincott Drug Guide for Nurses, Wolters Kluwer, page 436. (5) 2019 Lippincott Drug Guide for Nurses, Wolters Kluwer, page 436. 3. The facility staff failed to provide physician ordered treatments for Resident #22's pressure injuries on multiple dates in July 2021, August 2021 and September 2021. Resident #22 was admitted to the facility on 7/5/21. Resident #22's diagnoses included but were not limited to multiple sclerosis (1), seizures and major depressive disorder. Resident #22's quarterly minimum data set assessment with an assessment reference date of 9/24/21, coded the resident's cognition as severely impaired. Section M coded Resident #22 as two stage 3 pressure injuries (2).

PRINTED: 10/19/2021

**FORM APPROVED** 

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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F 686	Continued From page	e 177	F 686					
	the resident was adm injury on the right med Resident #22's clinica #22 acquired a stage	ilted with a stage 3 pressure dial heel. Further review of al record revealed Resident 2 pressure injury (2) on the						
	7/6/21 documented, "related to impaired mo pressure ulcer (injury) heel wound. Potential (related to) decreased incontinence, nutrition	Actual skin breakdown  bility, admitted with  to sacrum, right medial  for further impairment r/t  mobility, weakness,  al needs. Administer						
	order to cleanse the rig saline, apply Santyl (3 and cover with a dry d Resident #22's clinical treatment was provide 7/8/21, 7/10/21 and 7/	ght medial heel with normal ), apply calcium alginate (4) ressing daily. Review of record failed to reveal this d as ordered on: 7/6/21, 11/21, as evidenced by uly 2021 TAR [treatment and no nurses' notes nent was done. This			ei			
s a c f c b	order to cleanse the rig saline, apply medihone alginate and secure with day. Review of Reside ailed to reveal this trea ordered on: 7/19/21 an olank spaces on the Ju and no nurses' notes de	ed 7/15/21 documented an int medial heel with normal by (5), apply calcium in bordered gauze every ant #22's clinical record atment was provided as d 8/3/21, as evidenced by ly 2021/August 2021 TARs ocumenting the treatment ent was discontinued on						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		10/05/2021			
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F 686	F 686 Continued From page 178 8/14/21.  A physician's order dated 8/15/21 documented an order to cleanse the right medial heel with normal saline, apply medihoney, apply silver alginate (4) and secure with bordered gauze every day. Review of Resident #22's clinical record failed to reveal this treatment was provided on 8/25/21, 8/28/21, 8/29/21, 8/31/21, 9/1/21, 9/7/21 and 9/9/21, as evidenced by blank spaces on the August 2021/September 2021 TARs and no nurses' notes documenting the treatment was done.  A physician's order dated 8/24/21 documented an order to cleanse the left buttock with normal		F	686					
	#22's clinical record fai was provided on 8/29/2 9/9/21, as evidenced be August 2021/September nurses' notes documer done.  On 9/30/21 at 10:37 a.r. conducted with LPN (like LPN #7 stated the facilinurses but the nurses oneed to provide wound nurses are not available care treatments should TAR. LPN #7 further statement was provided On 10/4/21 at 4:40 p.m. staff member) #1 (the a	day. Review of Resident led to reveal this treatment 21, 9/1/21, 9/7/21 and y blank spaces on the er 2021 TARs and no sting the treatment was m., an interview was sensed practical nurse) #7. ty employs wound care on the medication carts care if the wound care e. LPN #7 stated wound be documented on the ated nurses cannot say if it is not documented.			• (3)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
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WESTFO		- NORSING CENTER	ĺ		RICHMOND, VA 23226			
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F 686	Continued From page	179	F	68	6			
	No further information	was presented prior to exit.						
	References:							
	disease that affects yo	(MS) is a nervous system our brain and spinal cord. It heath, the material that						
	surrounds and protect information was obtain	s your nerve cells." This led from the website:						
	meta?v%3Aproject≃m medlineplus-bundle&q	n.gov/vivisimo/cgl-bin/query- edlineplus&v%3Asources= uery=ms&_ga=2.53710894 i18-221748656.163353861						
		s localized damage to the						
	skin and underlying so		1					
		lated to a medical or other			- 2	28		
		present as intact skin or an					1,0	
		painful. The injury occurs nd/or prolonged pressure						
	or pressure in combina							
		for pressure and shear					ŀ	
		y microclimate, nutrition,						
	•	as and condition of the soft						
	tissue.							
		y: Partial-thickness skin						
	loss with exposed derπ Partial-thickness loss o		-					
	dermis. The wound bed						ļ	
	moist, and may also pre							
	ruptured serum-filled bl		-					
	•	r: Full-thickness skin loss						
		kin, in which adipose (fat)						
į i	is visible in the ulcer an	d granulation tissue and						
		dges) are often present."						
		otained from the website: /npiap.com/resource/resm						

STATEMENT OF	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. 8UILDING  (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
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ĺ	OVIDER OR SUPPLIER		730	EET ADDRESS, CITY, STATE, ZIP CODE 0 FOREST AVE HMOND, VA 23226	1 10/	/05/2021
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(find the state of	(3) "SANTYL Ointment prescription medicine of the program wounds so they conformation is taken frow website https://www.sa	pressure_injury_stages.pdf  It is an FDA-approved that removes dead tissue can start to heal." This om the manufacturer's antyl.com/.  It are absorbent wound care codium and calcium fibers They come in the form of be placed over open ulcers at are used for packing the luids and promote healing fiabetic foot ulcers, or formation is taken from the  com/2015/09/treating-wou inate-dressings/.  It all grade honey used for information was obtained  th.gov/pmc/articles/PMC26  and to provide treatments as an on multiple dates in imber 2021, to promote cer (1) for Resident #153.  The provide treatments as an on multiple dates in interesting the but were not limited to source ulcer of sacral driplegia (3).  The provided treatments as an on multiple dates in first and the provide treatments as an on multiple dates in first and the facility with but were not limited to source ulcer of sacral driplegia (3).	F 686			

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NAME OF	3701/1053 07 01/03	495227	B, WING	_		10	/05/2021
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	of 0 - 15, 12- being making daily decision Resident #153 having present on admission On 9/28/2021 at apprinterview was conducted their buttocks that the required dressing chat that most of the time to the dressing to the area by the dressing did not go or when the wound no stated that they did not go when the wound no because they wanted would be able to go he on 10/4/2021 at appropriation was condupractical nurse) #23 president #153. There the wound care observation was condupractical nurse in the wound care observation was condupractical nurse in the wound care observation was condupractical nurse in the wound care observation was condupractical nurse in the wound care observation was condupractical nurse in the wound care observation was conducted in part, "S	al status (BIMS) of a score inderately impaired for its. Section M documented grone stage 4 pressure ulcer it to the facility.  oximately 3:37 p.m., an ited with Resident #153. Ithat they had an area on y were admitted with that inges. Resident #153 stated the day nurses changed the just there were days when elet changed on the evenings are was off. Resident #153 of refuse wound care the area to heal so they ome.  oximately 2:00 p.m., an justed of LPN (licensed evoiding wound care to were no concerns during ration.  are plan for Resident #153 ikIN: [Resident #153] has	F	686			
r F W C	ulcer on admission and isk for further impairm nobility; incontinence [Revision on: 6/14/2021 Interventions/Tasks" it [Name of Wound Care vound care to follow are Initiated: 03/30/20 The physician orders for its following the physician orders for its following the physician orders for its following the physician orders for its following the physician orders for its formal intervention in the physician orders for its formal intervention in the physician orders for its formal intervention in the physician orders for its formal intervention in the physician orders for its formal intervention in the physician orders for its formal intervention in the physician orders for its formal intervention in the physician orders for its formal intervention in the physician orders for its formal intervention in the physician orders for its formal intervention in the physician orders for its formal intervention in the physician orders for its formal intervention in the physician orders for its formal intervention in the physician orders for its formal intervention in the physician orders for its formal intervention in the physician orders for its formal intervention in the physician orders for its formal intervention in the physician orders for its formal intervention in the physician in the physician intervention in the physician in the physician in the physician in the physician	documented in part, i] NP (nurse practitioner) nd treatments as ordered i21"				THE PARTY OF THE P	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C				(X3) DATE SURVEY COMPLETED	
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t co	dakins, pack with hydr saline) soaked PACKII with boarder [sic] foam evening shift for wound packing strips, as the repack into her wound Alplease use the packing too large to pack into honly for wound care for packing strips, as the repacking strips, as the repack into her wound. On the eTAR (electronic trecord) for Resident #1:8/1/2021-8/31/2021 failutealment completed to on 8/5/2021 on the 7-3 shift, 8/9/21 on the 3-11 shift, 8/27/21 on the 3-17-3 shift.  The eTAR for Resident #1:9/1/2021-9/30/2021 failutealment completed to be realment completed to the r	ogel AND NS (normal NH [sic] STRIPS, cover a gauze every day and of care please use the oil gauze is too large to ND as needed for soilage a strips, as the roll gauze is er wound AND one time of 1 Day please use the oil gauze is too large to Order Date: 9/2/2021."  eatment administration 53 dated ed to evidence the the sacral pressure ulcer shift, 8/9/21 on the 3-11 shift, 8/10/21 on the 7-3 of the sacral pressure ulcer shift, 8/10/21 on the 7-3 and the 3-11 shift, 9/17/21 on	F 686					

STATEMENT AND PLAN (	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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t t	performed on the eTAR care were witnessed by and documented in the reviewed the blanks on #153 for August and So above and stated that it that the wound care was documentation to supp there were times when wound care and they dimedical record and had witness the refusal.  On 9/30/2021 at 1:10 p. conducted with LPN #10 conducted with LPN #10 LPN #10 stated that the evidenced as completes that they could not deterwas completed or not signates on the eTARs in A 2021 for Resident #153. Resident #153 refused with LPN #8. wound care completion in the eTAR wound care were documentation on the eTAR wound care were documentation that the wood with the wood completes. LPN #8 documentation that the wood care were documentation that the wood with the wood care were documentation that the wood care were documentation that the wood care were were documentation that the wood care were documentation that the	e not working the floor wound care. LPN #4 care was documented as R and refusals of wound y another staff member e progress notes. LPN #4 n the eTARs for Resident eptember of 2021 listed they could not evidence as completed without ort it. LPN #4 stated that Resident #153 refused ocumented it in the if another staff member  .m., an interview was 0, the unit nurse manager. It treatments were d by documenting on the is notes. LPN #10 stated rmine if the wound care igned off on the blank lugust and September of . LPN #10 stated that wound care at times and it in the medical record.  .m., an interview was . LPN #8 stated that was evidenced by IAR and refusals of lented on the eTAR or the if there was no wound care was or in the progress notes	F 64	86	

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	] ' '			(X3) DAT	E SURVEY PLETED
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On 10/5/2021 at approper on the facility policy on wound the facility policy on wound the facility policy on wound the facility policy on wound the facility policy on wound the facility policy on wound the facility policy on wound the facility policy on wound services consistent of practice, research-dried terdisciplinary involve the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the severity of the facility of the severity of the facility of the severity of the facility of the severity of the facility of the severity of the facility of the severity of the facility of the severity of the facility of the severity of the facility of the severity of the facility of the severity of the facility of the severity of the facility of th	eximately 9:15 a.m., a ASM (administrative staff for of nursing, for the dicare.  Sing Policy and Procedure Documentation, Pressure agement" dated 02/2015 Any resident with a and will receive treatment it with accepted standards iven clinical guidelines, ment and the resident 's  simately 4:30 p.m., ASM mber) #1, the #2, the director of nursing a concern.  was provided prior to exit.  area of the skin that atthing keeps rubbing or n. Pressure sores are of symptoms. Stage I is IV is the worst. Stage I: on the skin that does not	F 686				
	CORRECTION  COUNTER OR SUPPLIER  TREHABILITATION AND SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page On 10/5/2021 at approper equest was made to A member) #2, the direct acility policy on wound the facility policy "Nurs lanual: Assessment & sigury and Wound man- coumented in part, " ressure injury or wour of services consistent practice, research-dr terdisciplinary involve bals of treatment"  In 10/4/2021 at approx diministrative staff me iministrator and ASM ere made aware of the of further information we ressure ulcer: is an eaks down when some easing against the skin puped by the severity mildest stage. Stage eddened, painful area	DENTIFICATION NUMBER:  495227  DVIDER OR SUPPLIER  TREHABILITATION AND NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 184  Do 10/5/2021 at approximately 9:15 a.m., a sequest was made to ASM (administrative staff nember) #2, the director of nursing, for the acility policy on wound care.  The facility policy "Nursing Policy and Procedure danual: Assessment & Documentation, Pressure by the services consistent with a ressure injury or wound will receive treatment and services consistent with accepted standards practice, research-driven clinical guidelines, terdisciplinary involvement and the resident 's bals of treatment"  In 10/4/2021 at approximately 4:30 p.m., ASM dministrative staff member) #1, the laministrator and ASM #2, the director of nursing are made aware of the concern.  In the formation was provided prior to exit.  Interences:  Pressure ulcer: is an area of the skin that teaks down when something keeps rubbing or assing against the skin. Pressure sores are suped by the severity of symptoms. Stage I: and all and a single I: addened, painful area on the skin that does not	DOUDER OR SUPPLIER  TREHABILITATION AND NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 184  On 10/5/2021 at approximately 9:15 a.m., a equest was made to ASM (administrative staff member) #2, the director of nursing, for the acility policy on wound care.  The facility policy "Nursing Policy and Procedure lanual: Assessment & Documentation, Pressure girry and Wound management" dated 02/2015 occumented in part, "Any resident with a ressure injury or wound will receive treatment and services consistent with accepted standards in practice, research-driven clinical guidelines, terdisciplinary involvement and the resident's shals of treatment"  In 10/4/2021 at approximately 4:30 p.m., ASM diministrative staff member) #1, the liministrator and ASM #2, the director of nursing are made aware of the concern.  In the formation was provided prior to exit.  In the services consistent with accepted standards in part in the liministrative staff member) #1, the liministrative staff member in the factor of	DOUDER OR SUPPLIER  A SUILDING  A SUILDING  B. WING  STREET ADDRESS, CITY, ST. 7300 FOREST AVE RICHMOND, VA 23226  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 184  On 10/5/2021 at approximately 9:15 a.m., a equest was made to ASM (administrative staff nember) #2, the director of nursing, for the acility policy on wound care.  The facility policy "Nursing Policy and Procedure lanual: Assessment & Documentation, Pressure july and Wound management" dated 02/2015 pocumented in part, "Any resident with a ressure injury or wound will receive treatment and services consistent with accepted standards practice, research-driven clinical guidelines, terdisciplinary involvement and the resident's pals of treatment"  In 10/4/2021 at approximately 4:30 p.m., ASM dministrative staff member) #1, the iministrator and ASM #2, the director of nursing are made aware of the concern.  Of urther information was provided prior to exit.  Inferences:  Pressure ulcer: is an area of the skin that eaks down when something keeps rubbing or easing against the skin. Pressure sores are supped by the severity of symptoms. Stage I is mildest stage, Stage IV is the worst. Stage I: addened, painful area on the skin that does not a white when pressed. This is a sign that a	DENTIFICATION NUMBER:  495227  A BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  7300 FOREST AVE RICHMOND, VA. 23225  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPTICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 184  On 10/5/2021 at approximately 9:15 a.m., a equest was made to ASM (administrative staff nember) #2, the director of nursing, for the acility policy "Nursing Policy and Procedure lanual: Assessment & Documentation, Pressure jury and Wound management" dated 02/2015 nocumented in part, "Any resident with a ressure injury or wound will receive treatment and services consistent with accepted standards practice, research-driven clinical guidelines, terdisciplinary involvement and the resident's basis of treatment"  In 10/4/2021 at approximately 4:30 p.m., ASM dministrative staff member) #1, the ministrator and ASM #2, the director of nursing are made aware of the concern.  In the content of the concern of the skin that the saks down when something keeps rubbing or issing against the skin. Pressure sores are supped by the severity of symptoms. Stage I is mildest stage. Stage IV is the worst. Stage I: addened, painful area on the skin that does not in while when pressed. This is a sign that a	CONTROL CORRECTION  (X1) PROVIDERSUPPLERCULA  495227  A BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  7300 FORESTA. OF CORRECTION  (RICHMOND, VA 23226  SUMMARY STATEMENT OF DESCRIBENCES  (RECH DESCRIBENCES)  (RECH DESCRIBENCES)  (RECH DESCRIBENCES)  (RECH DESCRIBENCES)  (RECH DESCRIBENCES)  (RECH DESCRIBENCES)  (RECH DESCRIBENCES)  (RECH DESCRIBENCES)  (RECH CORRECTIVE AND FORRECTION SHOULD BE CROSS-REPERRICED IOT THE APPROPRIATE DESCRIBENCES)  (RECH DESCRIBENCES)  (RECH CORRECTIVE AND FORRECTION SHOULD BE CROSS-REPERRICED IOT THE APPROPRIATE DESCRIBENCES)  (RECH DESCRIBENCES)

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD	LTIPLE CONSTRUCTION		E SURVEY PLETED
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	there is damage to the sometimes to tendons information was obtain https://medlineplus.gor/00740.htm.  2. Bipolar disorder: (formanic-depressive illnes a mental disorder that mood, energy, activity the ability to carry out of information is taken fronttps://www.nimh.nih.gorder/index.shtml.  3. Quadriplegia: "Paral function in part of your something goes wrong pass between your braican be complete or paraboth sides of your body one area, or it can be with lower half of your body one area, or it can be with lower half of your body one area, it can be with lower half of your body one area, or it can be with lower half of your body one area, or it can be with lower half of your body one area, it can be with lower half of your body one area, or it can be with lower half of your body one area.	e muscle and bone, and and joints. This led from the website: w/ency/patientinstructions/0 ermerly called ss or manic depression) is causes unusual shifts in levels, concentration, and day-to-day tasks." This m the website ov/health/topics/bipolar-dis lysis is the loss of muscle body. It happens when with the way messages in and muscles. Paralysis tial. It can occur on one or . It can also occur in just indespread. Paralysis of ody, including both legs, is ysis of the arms and legs formation is taken from paralysis.html.  In the did to transcribe a sure ulcer treatment to dent #129 pressure ulcer	F	686		
	Resident #129 was adm diagnoses that included cerebral infarction (2) an disease (3).	but were not limited to				

(X4) tD

PREFIX

TAG

PRINTED: 10/19/2021 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495227 B. WING 10/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE WESTPORT REHABILITATION AND NURSING CENTER RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 686 | Continued From page 186 F 686 Resident #129's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/4/2021, coded Resident #129 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section M documented Resident #129 not having any pressure ulcers. On 9/29/2021 at approximately 4:00 p.m., an interview was conducted with Resident #129. Resident #129 stated that staff applied an ointment to the area on the penis where the Foley catheter used to be but he was not sure how often they did it. Resident #129 stated that the area was healing. The comprehensive care plan for Resident #129 dated 4/2/2021 documented in part, "At risk for afteration in skin integrity related to history of chronic pressure ulcers, med (medication) use, incontinent episodes... Actual skin impairment as pressure to the posterior penis...Date initiated: 04/02/2021, Revision on: 09/28/2021," Under "Interventions/Tasks" it documented in part, "Treatment as directed, Date Initiated: 07/08/2021..."

penis.

The physician order summary for Resident #129 dated 9/30/2021 failed to evidence an order for a treatment to the pressure ulcer to the posterior

The progress notes for Resident #129 documented in part the following:

"9/20/2021 06:08 (6:08 a.m.) Note Text; Dr. Breton - MD (medical doctor) on call for [Name of physician) was contacted regarding pus-like

		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ļ	WESTP	ORT REHABILITATION AND	NURSING CENTER		7300 FOREST AVE RICHMOND, VA 23226	
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		discharge coming from stated that she will call "9/20/2021 07:49 (7:49 split and bleeding, has in color, with yellow drawith pain 7/10. Nurse of (responsible party), [Nation leave message, RP set up. Nurse informed will f/u (follow up) to cor "9/20/2021 09:50 (9:50 Physician/Practitioner in drainage - called [Nameurology NP (nurse practimuch appreciate recom today (UA C+S (urinalys sensitivity) ordered) - statempt voiding trial – (ordered cephalexin 500 a day) x10 days, renal dantibiotic ointment (ordered to tip of penis TID (three attempt voiding trial – (ordered cephalexin 500 a day) x10 days, renal dantibiotic ointment (ordered to tip of penis TID (three attempt voiding trial – (ordered urinary catheter) out for even up to 24 hrs [hours (hemodialysis)] (4) and a voiding) will follow up US (ultrasound) to assessa few days after voiding that today to regarding inflam orders for healing in the sat this time."  "9/20/2021 09:40 (9:40 a Physician/Practitioner noiwill also see him today. Heactroban to the penis ar	resident's penis. MD back at around 7am." a.m.) Note Text: Penis is an area yellow and green alnage coming from penis, alled Resident RP ame of RP], and attempted VM (voice mail) was not desk nurse this shift who ntacting the resident RP." a.m.) rote Purulent penile of urology practice] fitioner) for guidance- very mendations - culture urine sis with culture and art on cephalosporin red (milligram) BID (twice fosed) - start topical red bactroban application of times a day) x 7 days) - redered voiding trial for leave Foley (indwelling 12 hours [sometimes I] for those on HD assess for spontaneous voiding trial with bladder as residual volume within trial") Note Text: Resident and NP in to see him ed sore penis NP to add system awaiting update) teThe wound care NP le is currently applying and taking cephalexin	F 686		
		will also see him today. H	le is currently applying nd taking cephalexin			

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	almost no pain now the The wound care noted documented in part, "a.m.)From foley cather the care noted documented in part, "a.m.)From foley cather the care noted and the tip of the penis three states and ether the care noted and ether the care noted and ether the care noted and ether the care noted and ether the care noted and ether the care noted and ether the care noted and ether the care noted and ether the care noted and ether eth	s for Resident #129 9/23/2021 10:59 (10:59 h [catheter], Wound statusse? Yes, Etiology- Pressure use wound with Normal  medication administration 1-9/30/2021 for Resident ctroban olutment applied to ee times a day from 7/2021.  (electronic treatment for Resident #129 dated iled to evidence atment to the pressure  p.m., an interview was censed practical nurse) #4, N #4 stated that they kdays and every other ad the wound care. LPN #4	F 686				
ti k	nurse practitioner wher assess wounds. LPN if was evidenced by docu reatment administration hat they were aware the pressure ulcer to the per elean the area with norm to tin the physician orde ney had rounded with the new that was the treat	n record. LPN #4 stated nat Resident #129 had the enis and that they were to mal saline, however it was ers. LPN #4 stated that the nurse practitioner and ment that she had ordered ned the area when she					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		E CONSTRUCTION	(X3) DATE SUF COMPLET	
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F 1 p a	there was no order in a without an order for the documentation of treat could not evidence that done since 9/27/2021.  On 9/30/2021 at 1:10 p conducted with LPN #10 stated that the evidenced as complete eTAR or in the progres that they could not dete was completed if there treatment.  On 10/4/2021 at 11:36 conducted with LPN #8 floor nurses completed wound nurse was not the night shift. LPN #8 state were signed off on the trecord to evidence that could not be evidenced ordered.  On 10/4/2021 at approximation was a conducted with the evidenced ordered.  On 10/4/2021 at approximation in the trecord to evidence that could not be evidenced ordered.  On 10/4/2021 at approximation in the trecord to evidence that could not be evidenced ordered.  On 10/4/2021 at approximation in the trecord to evidence that could not be evidenced ordered.  On 10/4/2021 at approximation in the trecord to evidence that could not be evidenced ordered.  On 10/4/2021 at approximation in the trecord to evidence that could not be evidenced ordered.  On 10/4/2021 at approximation in the trecord to evidence that could not be evidenced ordered.  On 10/4/2021 at approximation in the trecord to evidence that could not be evidenced ordered.  On 10/4/2021 at approximation in the trecord to evidence that could not be evidenced ordered.  On 10/4/2021 at approximation in the trecord to evidence that could not be evidenced ordered.  On 10/4/2021 at approximation in the trecord to evidence that could not be evidenced ordered.  On 10/4/2021 at approximation in the trecord to evidence that could not be evidenced ordered.  On 10/4/2021 at approximation in the trecord to evidence that could not be evidenced ordered.	nplete the care because place. LPN #4 stated that e treatment and without iment on the eTAR they it any treatment had been on, an interview was 10, the unit nurse manager, e treatments were and by documenting on the s notes. LPN #10 stated ermine if the wound care was no order for a a.m., an interview was . LPN #8 stated that the wound care when the here and on evening and ed that the treatments reatment administration they were completed and as completed if not a concern.  It was provided prior to exit.	F	686			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER  ORT REHABILITATION AND	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	10/05/2021
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- 1	pressure reduces bloc of blood supply can ca area to become dama information was obtain https://medlineplus.gor 00147.htm.  2. Cerebrovascular dis accident: A stroke. Wi the brain stops. A strok "brain attack." If blood than a few seconds, th nutrients and oxygen. I lasting damage. This in from the website:	and supply to that area, Lack aruse the skin tissue in this ged or die. This sed from the website: w/ency/patientinstructions/0 sease, infarction or nen blood flow to a part of the is sometimes called a flow is cut off for longer	F 68	6	
F 689 F SS=E C	when your kidneys can body's needs. This info from the website: https://medlineplus.gov/  4. Hemodialysis: Dialys failure. It removes wast your kidneys can no long Hemodialysis (and other some of the job of the killyorking well. This inform he website:	c kidney disease. This is no longer support your armation was obtained dency/article/000500.htm. dis treats end-stage kidney e from your blood when ger do their job. If types of dialysis) does dneys when they stop mation was obtained from ency/patientinstructions/0 s/Supervision/Devices	F 689	1. Residents #111, #65, #19 remain in facility and care plan reviewed to ensure implementation of appropriate fall interventions. Resident #40 remains in facility provided with schedule for smokir times to enable supervision.	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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T 1 in fu	§483.25(d)(1) The res as free of accident haz supervision and assist accidents. This REQUIREMENT by: Based on observation, interview, facility documereview and in the cours investigation, it was deleast affailed to provide suinterventions to prevent residents in the survey #65, #19, and #40. The facility staff failed to implement fall prevention further falls, for Resident fells on 7/6/21 and 7/7/21 after the resident fells on 6/25/21 and for Resident fell on 1/5/21, 2/16/21 and provide supervision to supervision safety. The facility staff failed to implement fall prevention in a requiring supervision in a requiring supervision in a requiring supervision in the findings include:  The facility staff failed inplement fall prevention in the falls, after Reside 1/7/21.	ident environment remains cards as is possible; and addent receives adequate ance devices to prevent is not met as evidenced resident interview, staff ment review, clinical record are of complaint termined that the facility approvision, and accidents for four of 84 sample, Residents #111, or address and/or in interventions to prevent at #111 after the resident for 6/17/21, 6/24/21 and at #19, after the resident at #19, after the resident with the facility and failed to resident #40 was assessed while smoking for his	F	689	2. All resident's safety needs reviewed to ensure facilitation of assistive devices, supervision, at room free of hazards as appropriate.  3. DON or designee will provide facility nursing staff with education policy regarding following fall precautions and interventions, scheduled smoking times with expectations for supervision and assessment of room to ensure resolution of potential safety hazards.  4. DON or designee will audit 10° of all residents to ensure implementation of assistive devices, supervision with smoking and observation of room environment weekly times 4 weel and monthly times 2 to ensure facility maintains a safe environment for residents. Any identified issues will be immediate corrected. Results will be reported to Quality Assurance committee fanalysis and revision x 3 months.  5. Date of compliance will	nd  % g ks ely d or	4/19/2.1	

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i i i i i i i i i i i i i i i i i i i	resident's cognition as Section J coded Resident Section J coded Resident Section J coded Resident Programmer of Review of Resident Prevealed nurses' notes resident fell on 7/6/21  Review of fall investigates Resident #111's compitation of Fall investigates Resident #111's compitation of Falls were addressed for the 7/6/21, and 7/7/2.  On 9/30/21 at 10:37 auconducted with LPN (lieus LPN #7 stated when a should try to look at the identify the cause of the interventions to preven the facility policy titled, Managing* documented continues to fall, staff wind whether it is approgrammer current interventions current interventions continues to fall, staff wind whether it is appropriated.	sibetes, dementia and ident #111's quarterly ressment with an a date of 8/28/21, coded the severely impaired. Ident #111 as having falls since admission or a date of 8/28/21, coded the severely impaired. Ident #111 as having falls since admission or a date of the stand record set that documented the and 7/7/21.  Altions, nurses' notes and rehensive care plan dated to interventions to prevent seed and/or implemented 21 falls.  The production of the standard person, try to be fall and implement to future falls.  The production of the standard pers	F	689			
	essible causes that ma een identified,"	y not previously have					

	CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			_	NO. 0938-0391	
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Į	WESTPO	RT REHABILITATION AND	NURSING CENTER	1	300 FOREST AVE RICHMOND, VA 23226			
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	F 689	Continued From page		F 689				ĺ
		No further information	was presented prior to exit.					
implement further fails		2. The facility staff falle implement fall preventi- further falls, after Resid 6/24/21 and 6/25/21.	d to address and/or on interventions to prevent lent #65 fell on 6/17/21,					
		were not limited to diab muscle wasting. Residi minimum data set asse assessment reference of resident's cognition as s	5's diagnoses included but etes, breast cancer and ent #65's quarterly ssment with an date of 8/5/21, coded the severely impaired.					
	l n	Review of Resident #65 nurses' notes that docur on 6/17/21, 6/24/21 and				52.	84	
	R   1, ft	Review of fall investigation Resident #65's compreh 111/21 failed to reveal in Luture falls were address For the 6/17/21, 6/24/21 and the falls were address or the falls were and the falls were address or the falls were and the falls were address or the falls were address or the falls were address or the falls were address or the falls were address or the falls were address or the falls were address or the falls were address or the falls were address or the falls were address or the fall	ensive care plan dated nterventions to prevent ed and/or implemented					
	cc Li st id	PN #7 stated when a re	ensed practical nurse) #7. sident falls, the nurses individual person, try to fall and implement	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7				
		n 10/4/21 at 11:25 a.m. aff member) #1 (the ad-	, ASM (administrative					

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F 689	above concern.	194  j) were made aware of the  was presented prior to exit.	F 6	89						
implement fall preve further falls, after Ro 2/16/21 and 3/15/21		ed to address and/or on interventions to prevent dent #19 fell on 1/5/21,		a a						
	were not limited to mus falls and high blood pre quarterly minimum data	s diagnoses included but cle weakness, repeated assure. Resident #19's a set assessment with an date of 7/8/21, coded the severely impaired.	* *	•	3			19	34.	
r	Review of Resident #19 nurses' notes that docu on 1/5/21, 2/16/21 and 3							į		
F 1 fr	Review of fall investigati Resident #19's compreh 1/1/20 failed to reveal i uture falls were address or the 1/5/21, 2/16/21 a	ensive care plan dated nterventions to prevent sed and/or implemented								
c L si id in	PN #7 stated when a re hould try to look at that lentify the cause of the iterventions to prevent	ensed practical nurse) #7. esident falls, the nurses individual person, try to fall and implement future falls.								
0	n 10/4/21 at 11:25 a.m.	., ASM (administrative	1							۱

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114145 00 0		495227	B, WING				10	/05/2021
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	the director of nursing above concern.  No further information  4. The facility staff faild Resident #40 while he Resident #40 was assupervision while smo  Resident #40 was admit/28/19 with diagnose sclerosis, a brain injury most recent MDS (min assessment with an AF date) of 7/16/21, the rehaving no cognitive impleations, having score BIMS (brief interview for most according to the facility. He was observed staffont of the facility. He was moking.  On 9/28/2021 at 12:56 conducted with Resident #40 stated that he was not a sacility and that he only get some fresh air.	administrator) and ASM #2 g) were made aware of the  was presented prior to exit.  ed to provide supervision to smoked on 9/28/21.  essed as requiring king for his safety.  estimated to the facility on estinctuding multiple of an arrow and drug abuse. On the imum data set), a quarterly RD (assessment reference estident was coded as pairment for making daily ed 13 out of 15 on the error mental status).  Inately 10:00 a.m., Resident anding on the sidewalk in was unsupervised by staff,  p.m., an interview was at #40. When asked if he stated that he previously staff had taken his them up. Resident #40 allowed to smoke at the went outside at times to	F	689		·		
ir P	On 9/29/21 at 10:10 a.m nterviewed. He stated b revious morning. He st he facility staff not to sr							

PRINTED: 10/19/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		E SURVEY PLETED
			Í	<del></del>		С
		495227	B. WING_		10	/05/2021
	PROVIDER OR SUPPLIER	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D 8E	(X5) COMPLETION DATE
	his room before 9/28/2 previously kept smokin resident, as well. He stoutside, without staff si stated he was aware the anon-smoking facility, morning of 9/28/21 who smoking in front of the (administrator, had gone turn over all smoking momplied, and ASM #1 materials from his room A review of Resident #4 revealed the following previously the following previously the following previously the following previously the following previously the following previously the following previously the following previously the following previously the following previously the following previously the following previously the following previously the following previously the following previously the following following the following previously the following previously the following previously the following previously the following from the following previously the following from the following proviously the following previously the following from the following proviously the following previously the following from the front of the following; both denied he following; both denied he following; both denied he following previously the following; both denied he following; both denied he following; both denied he following previously the followin	erials on his person.  In had kept the materials in the stated he had also are materials for another tated he frequently went upervision, to smoke. He had the facility had become the stated that after the en he had been observed facility. ASM ember) #1, the ento him and asked him to naterials. He stated he had removed all smoking in.  It is clinical record progress notes:  In) Nursing/Clinical Note and verbal. No concerns of his time outside ingrediated on appears to not have in ites pain and discomfort, time. Call bell in reach, and update as needed."  In) Nursing/Clinical aking rounds this shift in the COVID unit writer with a female resident on the building; writer residents if they were overwerd.	F6			
	ince we are a non-smol			KE	·CEI	VED

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JFVL11

Facility ID: VA0270

NUV 2 9 2021 197 of 254



-	STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUILI		ECONSTRUCTION		TE SURVEY MPLETED
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I			495227	B, WING		····	1 1	0/05/2021
		ROVIDER OR SUPPLIER RT REHABILITATION AND			7.	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE RICHMOND, VA 23226		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREI TAG	FIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	F 689	Continued From page	197	F	689			
	t t t t t t t t t t t t t t t t t t t	safety assessment dat part: "Recommendation evaluation, determination smoker: Requires staff physical support or support or support of support of support of Resident # plan dated 5/27/20 and reveated, in part: "Possinot allowed on premise unauthorized smoking of the support o	on is as follows - At risk , family, or friend for pervision to smoke."  40's comprehensive care updated 4/13/21, pession of cigarettes/lighter sWill eliminate use/consumption."  LPN (licensed practical wed. She stated she Resident #40. She stated on the resident when he at provide 1:1 supervision ated she is not certain oking when he goes knows he has a history of outsideLPN #17 stated out whenever he leaves s stays on facility she was aware of what afety assessment g supervision while he was not.  LPN #18 was she frequently takes care ated the resident's for him to be go to PN #18 stated the cility's front porch. She the resident smokes the added, "They don't					

	TOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	CONSTRUCTION		ATE SURVEY MPLETED
		495227	B, WING			C
NAME OF	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	11	0/05/2021
WESTPO	RT REHABILITATION AND	NURSING CENTER	I	00 FOREST AVE CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(KS) COMPLETION DATE
. File sea bid coad sea	having a hard time enf smoking policy]."  On 10/4/21 at 3:39 p.m staff member) #2, the cinterviewed. She stated resident unsafe to leave front of the facility. She for himself when he lead stated a more recent stated a more recent stated a more recent stated y smoke. She stated smoking facility.  On 10/4/21 at 5:06 p.m. administrator, was infor the stated the facility is stated during the COVII about smoking had bee arrived at the facility with the had started to enforce stated the facility is actived as the facility is actived as the facility is actived as the facility is actived as the facility is actived as the facility is actived as the facility is actived as the facility is actived as the facility is actived as the facility of the facility power.	a., ASM (administrative director of nursing, was a no one has deemed the end his unit and go to the stated he is responsible eves the unit. ASM #2 moking safety evaluation the the resident's ability to ed the facility is a no ed the facility where ed the policy. ASM #1 rely involved in assisting to another facility where ed to another facility where ed to another facility where ed to another facility where ed to another facility is ed to another facility where ed to another facility is ed to another facility is a smoker, the ed consumption; assumption (traditional arettes; pipe, etc.); if a current smoker; with or without eted Safe Smoking	F 689			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) DATE S COMPLE	
		495227	B. WING		C	
NAME OF	PROVIDER OR SUPPLIER	177421	10,	STREET ADDRESS, CITY, STATE, ZIP CODE	10/0:	5/2021
WESTPO	ORT REHABILITATION AN	NURSING CENTER		7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENT FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPRIES OF THE PROPROPRIES OF THE PROPROPRIES OF THE PROPROPRIES OF THE PROPROPRIES OF THE PROPROPRIES OF THE PROPRIES OF THE PROP	BE	(XS) COMPLETION DATE
F 689	Physician and the Dire determine if safety res on a resident's smokin Safe Smoking Evaluat 8. A resident's ability to re-evaluated quarterly, (physical or cognitive) staff.  9. Any smoking-related and concerns (for exammonitoring) shall be not all personnel caring for alerted to these issues 10. The facility may import a resident at any time the resident cannot smay available levels of suppervision of a staff my visitor or volunteer worksmoking."	ector of Nursing Services to trictions need to be placed g privileges based on the ion.  In smoke safely will be a upon a significant change and as determined by the strictions, inple, need for close ited on the care plan, and it the resident shall be so se smoking restrictions in if it is determined that loke safely with the iort and supervision, estricted smoking privileges all have the direct ember, family member, ser at all times while	Fe			
SS=E	Respiratory/Tracheosto CFR(s): 483.25(i)  § 483.25(i) Respiratory tracheostomy care and The facility must ensure needs respiratory care, care and tracheal suctio care, consistent with propractice, the comprehen care plan, the residents and 483.65 of this subparations.	tracheal suctioning. that a resident who including tracheostomy ning, is provided such ifessional standards of sive person-centered goals and preferences,	F 69	1. Residents #501 no longer residents in the facility. Resident oxygen tubing was changed. Resident #145 oxygen setting w reviewed to ensure compliance physician order. Resident #165 incentive spirometer was replaced	es vith	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILO		PLE CONSTRUCTION		ATE SURVEY
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		495227	B, WING				10/05/2021
NAME OF	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTPO	ORT REHABILITATION AN	D NURSING CENTER			7300 FOREST AVE		
					RICHMOND, VA 23226		
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F 695	Continued From page	200					
	Tariminate Compagn		F	695	-		1
		is not met as evidenced			are at risk and have been revie		
	by:				to ensure physician order is in		
		n, resident interview, staff			and matches rate administered		
		ment review, clinical record			respiratory tubing and incentive		
	review, and in the cou	rse of a complaint			spirometers assessed for proper	er	
	investigation, it was di	etermined that the facility			storage.		
	staff failed to provide i services in accordance	espiratory care and	1		3. DON or designee will provide		
	standarde and the rec	ident plan of care for four of			facility nursing staff with educa		ļ.
	84 residents in the sur	vov sample. Residents			on policy regarding administrat	ion	
84 residents in the sur #501, #22, #145, and			1		of oxygen and storage of		
	1001, 1122, 1110, and	#100,			respiratory supplies to include		
	The facility staff admin	istered oxygen to Resident			incentive spirometers.		
	#501 without a physici	an's order, failed to store			4. DON or designee will audit 1		
	Resident #22's oxygen	tuhing in a clean and	İ		of all residents with oxygen and		
		to administer oxygen to	İ		incentive spirometers to ensure	!	
		hysician ordered rate, and			order for oxygen provided with		
İ	failed to ensure Reside	ent #165's incentive			matching rate administered and	i	
. [		ined in a sanitary manner.			proper storage of tubing and		
	,	· ·		٠	incentive spirometers weekly tir		
•	The findings include:	•			4 weeks and monthly times 2 to ensure that the facility meets		
	1. Resident #501 was a	admitted to the facility on	1		standards of practice for respira	ıtory	
	6/8/21 with diagnoses in	ncluding pulmonary			care. Any identified issues will be		
j	hypertension, bladder of	ancer, prostate cancer,			immediately corrected. Results		
1	and Parkinson's diseas	e. The resident was not in	!	ļ	be reported to Quality Assurance		
		to have a MDS (minimum			committee for analysis and revi	sion	Whoh 1
- 1	data set) assessment c	ompleted. On the		ł	x 3 months.		7//19/2-1
] ;	admission nursing asse	ssment dated 6/8/21,		- [	<ol><li>Date of compliance will be</li></ol>		
- 10	Resident #501 was doc	umented as not having	1				T.
] (	orders for supplemental	oxygen, or as receiving					¥ 94
	supplemental oxygen. F	Resident #501 expired at					
	the facility on 6/11/21.						
	A review of Resident #5						
ľ	evealed the following p	rogress notes:					
"	6/8/2021 18:33 (8:33 p.	m.) Resident Evaluation re normal. Lips/mucous					
	technicity, Itali ueus a	re normat, Lipstmucous	1	i			

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTR	UCTION			E SURVEY PLETED
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		495227	B, WING			•	10	/05/2021
	OVIDER OR SUPPLIER  T REHABILITATION AND	NURSING CENTER		7300 FORE	DRESS, CITY, STA ST AVE D, VA 23226	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTORS REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPR EFICIENCY)	BE	(XS) COMPLETION DATE
r s s s s s s s s s s s s s s s s s s s	6/9/2021 18:08 (6:08) Progress Note When I esident's sats (oxygen to 88% as he was just a varied. Oxygen whereased to 3 L NC (little o significant increase laced on a face mask NCAssessment/plar ypoxic respiratory failure oxygen at 3 L ote was written by the rovider was not available of the survey.]  1/10/2021 12:59 (12:59 (12:59 hysician/Practitioner Philef complaint): Acute illure, follow up shortner present illness]: Resid was noted to have (12 LPM [liters per miningen was increased to d his O2 sats improve est x-ray was ordered ocess. To best treat his	nk. No respiratory exygen orders are present."  p.m.) Physician/Practitioner first entered the room, the saturations) had dropped sitting in bed. The reading in assal cannula was ers via nasal cannula) with in sats. Resident was at 3 at 1. Acute on chronic are most likely secondary TN (hypertension).  NC continuously." [This nurse practitioner. This ble for interview at the p.m.)  Progress Note Text: CC hypoxic respiratory ess of breath. HPI [history dent was seen yesterday or coxygen) sats at 88% at 1. Acute in asal cannula and showed no acute is hypoxic respiratory.  PM by nasal cannula	F 69	5				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTIO	N		SURVEY
		495227	B. WING _				C /05/2021
ĺ	NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER			STREET ADDRESS 7300 FOREST AV RICHMOND, VA	_	DDE	 03/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF C H CORRECTIVE ACTIV REFERENCED TO TH DEFICIENCY	ON SHOULD BI	(X5) COMPLETION DATE
	A review of Resident is dated 6/8/21 revealed respiratory impairment physician order."  On 9/30/21 at 11:13 a nurse) #14 was interviews #501 received oxygen reviews the physician rate of oxygen administrated the resident must because oxygen is a nishe could not recall with had an order for oxygen problem with an oxygen physician or nurse practical materials. The control of the problem with an oxygen orders for Resist was not certain where the interviewed. She stated oxygen orders for Resist was not certain where the interviewed ability to enter the order in them actually entering them actually entering the focumentation demonstration of the problem of the problem of them actually entering the standard.  On 10/4/21 at 5:06 p.m. administrator, was information, Lippincott Williams (Coording to Fundamer Edition, Lippincott Williams). "Because oxygen in the standard of the problem of	#501's baseline care plan I, in part: "Has/At risk for tAdminister oxygen per Im., LPN (licensed practical lewed. She stated Resident all the time. She stated she is order to determine the stration for residents. She st have an order for oxygen medication. LPN #14 stated mether or not Resident #501 m. She stated if there is a m order, she calls the ctitioner to clarify it.  a., ASM (administrative director of nursing, was d she did not find any dent #501. She stated she the error was. She stated oner or the nurse had the rs, but it looked like a ch resulted in neither of the orders. ASM #2 stated ars, the nurse practitioner's strated the resident was a time. She stated the as its professional  ., ASM #1, the med of these concerns.	F 69	5		*27	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE S	
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		495227	B, WING			10/0	5/2021
	PROVIDER OR SUPPLIER	D NURSING CENTER	73	TREET ADDRESS, CITY, STATE, 2 300 FOREST AVE ICHMOND, VA 23226	ZIP CODE		
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	permit the nurse to ad emergency situations immediately available oxygen is generally sa certain precautions mudrugs, the potential exmisuse."  A review of the facility "Medication/Treatment "Medications and/or treonly upon the clear, co a person lawfully author to the complaint Deficiency 2. The facility staff fails oxygen tubing in a clear conduction of the complaint of the complaint person to the complaint of the complaint person to the complaint and major depressive of the complaint of the	minister oxygen in if the physician is not to write an order. Although of when used properly, ust be observed. As with all ists for causing harm with policy, orders," revealed, in part: eatments are administered implete and written order of orized to prescribe."  was provided prior to exit.  and to store Resident #22's in and sanitary manner.  itted to the facility on diagnoses included but iple sclerosis (1), seizures isorder. Resident #22's is set assessment with an olate of 9/24/21, coded the reverely impaired.  and #22 as totally ed mobility and transfers.  's clinical record revealed diagnoses of sygen tevel.  and 9/29/21 at 10:45 observed lying in bed, not	F 695				
	eceiving oxygen. The roncentrator was agains	esident's oxygen It the wall and the nasal					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	CONSTRUCTION	10	(X3) DATE SURVEY COMPLETED
		495227	8. WING			C 10/05/2021
	PROVIDER OR SUPPLIER	NURSING CENTER	730	REET ADDRESS, CITY, STATE, ZIP COI 00 FOREST AVE CHMOND, VA 23226	DE	
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	cannula oxygen tubing the concentrator. The and was exposed to a On 9/30/21 at 10:37 a. conducted with LPN (ILPN #7 stated oxygen a sealed bag when no not grow on it.  Resident #22's compre 7/5/21 failed to documoxygen storage.  On 10/4/21 at 11:25 a. staff member) #1 (the action of nursing above concern.  The facility policy titled failed to document info tubing storage.	was observed on top of tubing was not covered ir.	F 695			
	disease that affects you damages the myelin sh surrounds and protects information was obtaine https://vsearch.nlm.nih.meta?v%3Aproject=memedlineplus-bundle&qu.747995928.1633538618	your nerve cells." This				

PRINTED: 10/19/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING 495227 B. WING 10/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE WESTPORT REHABILITATION AND NURSING CENTER RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 695 Continued From page 205 F 695 Resident #145 at the physician ordered rate.

Resident #145 was admitted on 9/3/21 with the diagnoses of but not limited to COVID-19, respiratory failure, atrial fibrillation, and hypothyroidism. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 9/9/21. Resident #145 was code as being cognitively impaired in ability to make dally life decisions. The resident was coded as requiring extensive assistance for bathing, hygiene, toileting, dressing, and bed mobility; and limited assistance for transfers and eating.

On 9/28/21 at 12:53 PM, an observation of Resident #145 and the resident's oxygen was conducted. Resident #145 was observed receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. The oxygen flow rate was set at 1 liter per minute, as evidenced by the flow meter ball set on the 1 liter line with the line positioned through the center of the flow meter ball.

A review of the clinical record revealed a physician's order dated 9/4/21 for "Oxygen Therapy Oxygen at: 2 Liters/minute Via: NC (nasal cannula)."

A review of the comprehensive care plan revealed one dated 9/13/21 for "Has/At risk for respiratory impairment related to covid 19. acute respiratory failure with hypoxia." This care plan included an intervention dated 9/13/21 for "Administer oxygen per physician order."

On 10/4/21 at 2:30 PM, an interview was conducted with LPN #8 (Licensed Practical

CENTE	RS FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION		E SURVEY PLETED
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	· <del></del>	495227	B, WING			10	/05/2021
	PROVIDER OR SUPPLIER RT REHABILITATION AN	D NURSING CENTER	i	7300	EET ADDRESS, CITY, STATE, ZIP CODE  POREST AVE  HMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 695	Nurse) the unit manag oxygen was set at 1 li	ger. When asked if the ter and the order was for 2 being administered as	F	695			
	concentrator document properly read the flow flowrate line on the flow	meter, locate the prescribed wmeter. Next, turn the flow s to the line. Now, center					
	so that it is comfortable	ented, "Review the			#		
	Staff Member) the Adm Director of Nursing, wa	, ASM #1 (Administrative ilnistrator, and ASM #2, the s made aware of the ormation was provided by		5		***	
	4. The facility staff faile #165's incentive spirom sanitary manner.	ed to ensure Resident eter was maintained in a					
2 2 3 4 4	dood pressure, diabete The Admission MDS (M	es of but not limited to aphasia, dysphagia, high s, and hypothyroidism. inimum Data Set) with an rence Date) of 9/16/21 s being cognitively					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495227	B, WING			С
NAME OF I	PROVIDER OR SUPPLIER	493227	1 5. 11110_	STREET ADDRESS, CITY, STA	TE ZIP CODE	10/05/2021
WESTPO	RT REHABILITATION AN	D NURSING CENTER		7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRI EFICIENCY)	
F 695	The resident was code	ed as requiring extensive	F6	595		
		ene, toileting, and transfers; dressing and eating; and wel and bladder.				
	On 9/28/21 at 12:50 P observed up in his who lunch. An uncovered i observed on the overb	eelchair in his room eating ncentive spirometer was				
ŀ	On 9/29/21 at 8:45 AM observed in his wheeld incentive spirometer witable, uncovered. Whe incentive spirometer, R he uses it sometimes.	chair in his room. The as still on the overbed				
	the column and continu (approximately) 3 secon	9/14/21 for "Incentive sident - Place the uth, sealing your lips slowly and deeply as e piston toward the top of e to hold for - nds before exhaling.				
i i	On 10/4/21 at 2:30 PM, conducted with LPN #8 Nurse) the unit manage ncentive spirometer shun use, LPN #8 stated the page.	(Licensed Practical				
A	Spirometry" did not inclu	olicy for "Oxygen apeutics Topic: Incentive ide directions regarding ice in a sanitary manner				

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, 7	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ĺ		495227	B. WING_		10/05/2021
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MEGERO	OT DELLA DU IMARIANI ANI			7300 FOREST AVE	
WESTPO	RT REHABILITATION AND	NURSING CENTER		RICHMOND, VA 23226	
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F 695	Continued From page when not in use.	208	F 6	95	
SS=E	Staff Member) the Adribited to Poirector of Nursing, was findings. No further interest the end of the survey. Pain Management CFR(s): 483.25(k)  §483.25(k) Pain Management The facility must ensurprovided to residents was consistent with profess the comprehensive per and the residents' goal. This REQUIREMENT by:  Based on observation, interview, clinical record facility staff failed to limit management program of the survey sample, Resident #153 on multiple and September 2021.  The findings include:  Resident #153 was admitiagnoses that included bipolar disease (1), presegion, stage 4 (2) and designoses that of the survey sample and september 2021.	gement, e that pain management is the require such services, ional standards of practice, son-centered care plan, is and preferences, is not met as evidenced resident interview, staff direview and facility is determined that the plement a complete pain for one of 84 residents in inident #153.  In attempt /provide terventions prior to dipain medication to ple dates in August 2021 with but were not limited to	F 69	1. Resident #153 remains in cen new order for non-pharmacologic interventions received. 2. All residents with prn pain medications ordered will receive pain management program to include non-pharmacological interventions 3. DON or designee will provide facility nursing staff with education principles on non-pharmacological pain interventions prior to administration of prn pain medications. 4. DON or designee will audit 10 of all residents with prn pain medications to ensure provisions non-pharmacological intervention were attempted prior to administration of pain medication weekly times 4 weeks and month times 2 to ensure that the facility free of unnecessary medication administration. Any identified issuill be immediately corrected. Results will be reported to Qualit Assurance committee for analysi and revision x 3 months. 5. Date of compliance will be	on  on  s of  ns  nly  is  ues

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	reference date) of 9/1 #153 as scoring a 12 mental status (BIMS) being moderately imp decisions. Section J of receiving scheduled at medications. Section #153 as receiving nor interventions for pain frequently.  On 9/28/2021 at approximately interview was conduct Resident #153 stated medications often for oil frequently interventions prior to a pain medications, Resident #153 stated medications, Resident #153 stated interventions prior to a pain medications, Resident #153 stated interventions, Resident #153 stated wound & decline in head (range of motion) to Bill extremities) and LUE (Icontracture and spasme Initiated: 02/11/2021, Resident #152021, Res	t with an ARD (assessment 3/2021, coded Resident on the staff assessment for of a score of 0 - 15, 12-aired for making daily coded Resident #153 as and as needed pain. J further coded Resident a-pharmacological and as having pain.  Description of the process of the pain	F					

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING \_ Ç 495227 B. WING 10/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE WESTPORT REHABILITATION AND NURSING CENTER RICHMOND, VA 23226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION OATE PREEIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 697 Continued From page 210 F 697 \*Controlled Drug\* Give 1 (one) tablet by mouth every 12 hours as needed for Pain related to CHRONIC PAIN SYNDROME. Order Date: 7/14/2021," The eMAR (electronic medication administration record) dated 8/1/2021-8/31/2021 for Resident #153 documented administration of the as needed Oxycodone on the following dates/times: - 8/3/21 at 3:00 a.m. and 3:03 p.m. - 8/7/21 at 6:09 a.m. - 8/9/21 at 3:14 p.m. - 8/10/21 at 2:28 p.m. - 8/11/21 at 2:16 a.m. - 8/13/21 at 2:18 a.m. - 8/15/21 at 2:17 a.m -8/16/21 at 12:41 a.m. and 2:44 p.m. -8/17/21 at 3:11 a.m. and 3:13 p.m. - 8/18/21 at 4:39 a.m. and 6:57 p.m. - 8/19/21 at 1:56 p.m. - 8/20/21 at 2:29 p.m. - 8/21/21 at 2:56 p.m. - 8/22/21 at 2:43 a.m. and 2:43 p.m. - 8/25/21 at 2:40 a.m. - 8/27/21 at 2:23 a.m. and 2:36 a.m. - 8/30/21 at 3:06 p.m. - 8/31/21 at 2:43 p.m. The eMAR failed to evidence documentation of non-pharmacological interventions attempted prior to administration of the Oxycodone on these dates. The eMAR dated 9/1/2021-9/30/2021 for Resident #153 documented administration of the as needed Oxycodone on the following dates/times\* - 9/2/21 at 2:10 a.m. - 9/4/21 at 2:31 a.m. and 2:35 p.m.

-9/8/21 at 2:30 a.m.

PRINTED: 10/19/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	non-pharmacological in prior to administration of dates. The progress notes for evidence documentation	m. and 3:20 p.m.  l.m. l.m. l.m. l.m. l.m. l.m. l.m.	E	697					
ir a L	nterventions were attended administration of as need PN #13 stated that the	ded pain medications. y attempted things like it first and if that did not							
th re ne at an m	ne as needed pain med esident. LPN #13 state on-pharmacological inte	ications ordered for the d that the erventions were they may refleve the pain on of unnecessary tated that they		7748.					

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	interventions in a nurs what other staff did. L non-pharmacological i documented to eviden On 9/30/2021 at 1:10   conducted with LPN # LPN #10 stated that repositioned residents non-pharmacological in relieved the pain to pre medications being admithat the staff should do non-pharmacological in prior to the administrati medication on the medication on the medication on the medication they could be non-pharmacological in prior to the administrati medication on the medication on the medication on the medication they could be non-pharmacological in prior to the administrati medication on the medication on the medication on the medication on the medication on the medication they could be non-pharmacological in prior to the work they conducted with LPN #8. The sidents were offered in the residents were offered in the residents were offered in the staff shadows. LPN were offered snacks, a conducted with shadows.	tes note but was not sure IPN #13 stated that the interventions should be ice that they were done.  p.m., an interview was 10, the unit nurse manager. It is idents were asked to rate ered non-pharmacological it is administration of pain it is tated that they and other interventions to see if they went unnecessary initistered. LPN #10 stated cument the interventions attempted on of the as needed pain it is the staff were not in the staff were not in they were doing.  If not evidence that they and they were not taking were doing.  In IPN #8 stated that inon-pharmacological ministration of as needed #8 stated that residents quiet room or	F	697	DEFIC	iency)		
d w ti d	epositioning. LPN #8 s lone because at times t without the use of the m hat the non-pharmacold locumented in the medi otes. LPN #8 stated th on-pharmacological intropers.	tated that these were hey relieved the pain edication. LPN #8 stated egical interventions were cal record in the progress at if the						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(F	(X3) DATE SURVEY COMPLETED
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	administration of as new Con 10/5/2021 at approrequest was made to Amember) #2, the direct facility policy on pain in The facility policy on pain in Management" dated Minagement dated Minagemen	re attempted prior to the seded pain medications.  eximately 9:15 a.m., a a assistant state of nursing, for the nanagement.  Assessment and arch 2015 documented in this procedure are to help the resident, and to hat are consistent with the eds and that address the ainNon-pharmacological oppropriate alone or in attons. Some terventions include: a. In the resident, and the room temperature, roviding a ress, repositioning, etc.; b. of or warm compresses, electrical nerve stimulation puncture, etc.; c. Exercise ses to prevent muscle as; and d. Cognitive or music, diversions, and the medication regimen cumenting the results of ment the resident's the adequate detail (i.e., auge the status of pain interventions for pain) as lance with the pain	F 697		NO K	RECEIVE WAR

PRINTED: 10/19/2021 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495227 B. WING 10/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE WESTPORT REHABILITATION AND NURSING CENTER RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 697 Continued From page 214 F 697 were made aware of the concern. No further information was provided prior to exit. References: 1. Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipotar-dis order/index.shtml. 2. A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0 00740.htm. 3. Quadriplegia: "Paralysis is the loss of muscle function in part of your body, it happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia." This information is taken from the website

https://medlineplus.gov/paralysis.html.

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	4. Neuropathy: Nerve was obtained from the https://www.google.co/ <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a> <a href="https://www.google.co/">https://www.google.co/</a>	damage. This information website: m/#q=neuropathy+nih om/>.  e that residents who such services, consistent ards of practice, the -centered care plan, and if preferences. It is not met as evidenced w, resident interview, w and clinical record and the facility staff failed to nunication and alysis facility for one of 84 0.  e evidence ongoing aboration with Resident fultiple diatysis progress and or missing in June 2021 and September  tited to the facility on a diagnoses included but etes mellitus (1), end	F 698		ith  on s % bks  nd he ied  d for	11/19/21	
	Resident #110's most red set) assessment, a quart	cent MDS (minimum data erly assessment, with an					

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3 6 7 7 7 8 8 8	resident as scoring 15 (brief interview for mer the resident was cogning G-Functional Status: or requiring limited assist walking, locomotion, driving limited assist walking, locomotion, driving limited assist walking, locomotion, driving limited assist walking, locomotion, driving limited assist walking, locomotion, driving limited assist walking, locomotion, driving limited assist walking, locomotion of the compression of the procession of the physicial documented in part, "HESRD Dialysis Days: Marview of the physicial documented in part, "HESRD Dialysis Days: Marview of Resident #1 containing the "Dialysis section to be completed to the procession of the completed was completed, were from 6/1/21-9/28/28/28 missing forms for the 5/19/21, 6/22/21, 6/26/2/25/21, 7/7/21, 7/9/21, 7/2/19/21, 7/2/19/21, 7/2/19/21, 7/2/19/21, 7/2/19/21, 7/2/19/21, 7/2/19/21, 7/2/19/21, 7/2/19/21, 7/2/1/21, 7/2/19/21, 7/2/	date of 8/27/21, coded the out of 15 on the BIMS hal status) score, indicating tively intact. MOS Section coded the resident as ance for mobility, transfers, ressing, bathing and pecial Treatments and eresident as dialysis 'yes'.  Thensive care plan dated 17/21, documented in part, ciency related to e and required 'ENTION: Dialysis four ay/Wednesday/Friday and the modern and the code and required 'ENTION: Dialysis four ay/Wednesday/Friday and the modern and the code and required 'ENTION: Dialysis four ay/Wednesday/Friday and the modern and the code and the c	F6	698			

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F 698	Continued From page	217		698	R				
:	' *	ent #110. When asked if	'	030	1		1 .		
	i	der, Resident #110 stated,					1		
		here are forms in there							
i	from here and the dial	ysis center."	ŀ						
	On 9/28/21 of 6:20 DM	l the 22 mission districts							
		I the 32 missing dialysis for Resident #110 were			•				
	requested from ASM (a						II.		
		nistrator and ASM #2, the	1				Ĺ		
	director of nursing.								
	On 0/20/24 at 6:20 DM								
1	ASM (administrative st	, a request was made of	-						
	•	#2, the director of nursing							
		sis communication forms							
	for Resident #110.				1				
	On 9/29/21 at 8:30 AM	dialysis communication							
		r Resident #110 by ASM					I.		
		ysis communication forms	1.0		20 00°	4 9			
		1- a total of 13 forms with					-		
		vided missing dates with							
	none of these forms co	relating to any of the			1				
:	missing dates listed abo		ı	ĺ					
1	In the group of dialysis								
		total of 15 forms with 11							
		d missing dates with none							
	dates listed above	ng to any of the missing			_				
- 1	n the group of dialysis	communication forms	- [		l Ri	Comme			
	abeled July 2021- a total			-		ECEN	(FD)		
	provided with one of one				ñ.		140		
		ating to any of the missing			I NU	V 29 20 H/OL	704		
1 -	lates listed above.	2013			-	-0 20	<i> 4 </i>		
	n the group of dialysis o				VD	M/n			
i		al of 11 forms with five of			, 0	11/07			
	•	issing dates with none of	-	ļ		-			
	hese forms correlating t	to any of the missing							
Q	lates listed above.		1	- 1			E.		

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F 698	Continued From page	218	F	698	117				
	nursing stated, "Yes, t communication forms are the ones we provide	we have for Resident #110 ded. I know some of them we have no idea of what							
	When asked the purpo note, LPN #5 stated, "I communication from the asked what information #5 stated, "It is to provi	censed practical nurse) #5. use of the dialysis progress it is to provide and receive the dialysis center." When the was to be provided, LPN tide vital signs, any ken, and any issues with							δ
	member) #1, the admin	ASM (administrative staff istrator and ASM #2, the made aware of the above			·r.,	ů.	83		17
ii b	documented in part, "In the residents care will b now the care plan will b mplemented, how infor	ident with revised 9/10, cludes all aspects of how e managed including: e developed and mation will be exchanged and responsibility for waste						4	
1	o further information w	as provided prior to exit.							
(°	ormally in the body. Ba	bility of insulin to function rron's Dictionary of on-Medical Reader, 7th							

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SS=D	edition, Rothenberg and (2) End stage of renal kidneys to excrete was maintenance of electro. Dictionary of Medical Treader, 7th edition, Repage 498.  (3) Schizophrenia is macharacterized by gross withdrawal from social of thought, language, presponse. Barron's Diction of the Non-Medical Resolution of the Non-Medical Resolution of the Non-Medical Resolution of the Non-Medical Resolution of the Non-Medical Resolution. The facility must attempalternatives prior to instance a bed or side rail is use correct installation, use rails, including but not like the elements.  §483.25(n)(1) Assess the entrapment from bed rails with the reside representative and obtain installation.  §483.25(n)(3) Ensure the are appropriate for the new 18483.25(n)(4) Follow the 18483.25(n)(	nd Chapman, page 160. failure-inability of the stes and function in the objet balance. Barron's ferms for the Non-Medical othenberg and Chapman, ental disorder distortions of reality, contacts and disturbances perception and emotional tionary of Medical Terms eader, 7th edition, man, page 518.  It out to use appropriate alling a side or bed rail. If d, the facility must ensure , and maintenance of bed mited to the following  the resident for risk of fits prior to installation.  the risks and benefits of out or resident fin informed consent prior at the bed's dimensions esident's size and weight.	F 700		#67 de rail use s cted

		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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Į	NAME OF P	ROVIDER OR SUPPLIER	<u></u>		STREET ADDRESS, CITY, STATE, ZIP CODE			
l	WESTPOR	WESTPORT REHABILITATION AND NURSING CENTER				300 FOREST AVE		
ļ	THE TOTAL PRINCIPLE IN THE PRINCIPLE OF				R	RICHMOND, VA 23226		<del></del> -
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(XS) COMPLETION DATE
		by: Based on staff interviereview, it was determinances the risks and both 84 residents in the staff and Resident #6 The facility staff failed benefits for the use of reviewed with Resident prior to use of side ralls. The findings include  1. The facility staff failed	ails. is not met as evidenced ew and facility document med the facility staff failed to enefits of side rails for two survey sample, Resident 7. to evidence that the risks / side rails had been at #127 and Resident #67 s.	F	700	4. DON or designee will audit 1 of all residents to ascertain if sir rails are in use and supporting documentation of education on risks/benefits was provided westimes 4 weeks and monthly time to ensure that the facility meets guidelines for use of side rails, identified issues will be immedia corrected. Results will be report to Quality Assurance committee analysis and revision x 3 month 5. Date of compliance will be	de  akly es 2 the Any ately ted e for	1,11912]
		were not limited to: dial insulin to function norm chronic obstructive pulit (chronic and non-reverseongestive heart failure congestion and retentic kidneys) (3).  Resident #127's most a data set) assessment, a with an assessment refooded the resident as s	mitted to the facility on 7's diagnoses included but betes mellitus (Inability of hally in the body) (1), monary disease 'COPD' sible lung disease) (2) and b'CHF' (circulatory on of salt/water by the ecent MDS (minimum an annual assessment, herence date of 9/3/21, heroring a 13 out of 15 on w for mental status) score, was cognitively intact. honal Status: coded the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		ATE SURVEY
			13.5	<u> </u>		С
		495227	B. WING		1 1	10/05/2021
1	PROVIDER OR SUPPLIER RT REHABILITATION AND	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD 8E	(X5) COMPLETION DATE
	mobility, transfers, dre bathing, walking and keating. A review of Bladder: coded the refor bowel and for bladders and for bladders and for bladders and for bladders and for bladders. A review of Resident #plan dated 4/30/20, don "FOCUS-ADL (activities deficit related to physic weakness, easily fatigu INTERVENTIONS-Encodevices as able."	ssing, personal hygiene, personal hygiene, personal hygiene, personal hygiene, personal hygiene, personal hygiene, served in bed with bilateral at 8:00 AM, 9/30/21 at tt 8:00 AM.  127's comprehensive care cuments in part, s of daily living) self-care al limitations from muscle ed and pain.	F 70			
t a fi	documented in part, "Be Bed rails will assist the balance, supporting sell entering bed more safet and providing sense of that apply: a. Bed rail ris precautions were discus- and/or patient represent to bed rails were discus- and/or patient represent or #22 were unchecked On 9/29/21 at 10:00 AM conducted with Residen used the bed rails, Residen they help me to turn and On 9/30/21 at 11:00 AM	patient by: Improving f, exiting bed more safely, y, transferring more safely security. #22: check all sks, benefits and sed with the patient ative and b. Alternatives sed with the patient ative." Box a. and box b. and blank.  an interview was t #127. When asked if he dent #127 stated, "Yes, reposition myself."  and interview was ensed practical nurse) #5.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B, WING			41	C 0/05/2021	
	NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			310-312-02-1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	8E	(X5) COMPLETION DATE	
	evaluation, LPN #5 steevaluate the resident's review the risks and been continued in the co	ated, "The purpose is to so need for the bed rails, enefits and obtain consent."  A, ASM (administrative staff inistrator and ASM #2, the re made aware of the above in the ab	·	700				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB N	IO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	CIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION			E SURVEY IPLETED		
							С
<u> </u>		495227	B. WING			10	0/05/2021
NAME OF P	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTRO	RT REHABILITATION ANI	A MIDONO OFFITED		] 7	7300 FOREST AVE		
		D NORSING CENTER		F	RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	8/2/16. Resident #67' were not limited to: particle lower limbs) (1), chron disease 'COPD' (chron disease) (2) and osteo form of arthritis characteristic changes in the joints) (1). Resident #67's most reset) assessment, a quassessment reference resident as scoring a 1 (brief interview for mentitle resident was cogniting G-Functional Status: cextensive assistance with the resident was cogniting for t	s diagnoses included but araplegia (paralysis of the lic obstructive pulmonary nic and non-reversible lung parthritis (most common sterized by degenerative (3).  The cent MDS (minimum data arterly assessment, with an date of 8/4/21, coded the 5 out of 15 on the BIMS stall status) score, indicating tively intact. MDS Section coded the resident, as with bed mobility, transfers, personal hygiene and to occur. Eating was A review of MDS Section coded the resident as	F	700			
A dd e	Resident #67 was obse side rails in the up position PM, 9/29/21 at 9:00 AM A review of Resident #6 plan dated 1/9/20, docuisk for falls/injuries due chronic fatigue and impart NTERVENTIONS-Side as enablers."  A review of the physicial locumented in part, "1/2 prablers to turn and rep	erved in bed with bilateral tion on 9/28/21 at 2:00 t and 9/30/21 at 9:55 AM.  67's comprehensive care ments in part, "FOCUS-At to generalized weakness, aired mobility.  rails at head of bed. Uses on orders dated 5/15/19, 2 side rails up in bed as to sittion due to weakness".					

		MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATÉ SURVEY COMPLETED			
İ			495227	B, WING					1,	C 0/05/2021	
		OF PROVIDER OR SUPPLIER TPORT REHABILITATION AND NURSING CENTER			7300 F	TADDRESS, OREST AVE	CITY, STATE, ZIP CO	OE	,	710372021	
	(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTIC ( (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)				(X5) COMPLETION DATE		
	Caw Cld On N	entering bed more safe and providing sense of that apply: a. Bed rail in precautions were discussed and/or patient represent to bed rails were discussed for #22 were unchecked. On 9/29/21 at 9:00 AM, conducted with Resider used the bed rails, Residery and/or patient represent for #22 were unchecked. On 9/29/21 at 9:00 AM, conducted with Resider used the bed rails, Residery and the property of th	patient by: improving If, exiting bed more safely, ly, transferring more safely security. #22: check all isks, benefits and assed with the patient stative and b. Alternatives sed with the patient stative." Box a. and box b. d.  an interview was and #67. When asked if she ident #67 stated, "Yes, hysical therapy is working and they stabilize me with  and interview was ensed practical nurse) #5 e of the bed rail ed, "The purpose is to need for the bed rails, nefits and obtain consent."  ASM #1, the #2, the director of nursing above findings.  ASM #2 stated, "I will ons for Resident #67."  ASM #2 stated, "There is bed rails."  as provided prior to exit.	F	700						
	[ (1	) Barron's Dictionary of	Medical Terms for the		1						

					OMB NO. 0938-039
AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495227	B. WING		C
NAME OF P	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP CODE	10/05/2021
	·		- 1		
WESTPO	RT REHABILITATION AND	NURSING CENTER	1	7300 FOREST AVE	
	· · · · · · · · · · · · · · · · · · ·			RICHMOND, VA 23226	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(XS)
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		OO IDCHT IL LING HALOUMMI (IOM)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE
			<del>-</del>		
F 700	Continued From page		F 700		
- 1	Non-Medical Reader,	7th edition, Rothenberg and			[
- 1	Chapman, page 432.			ļ	ļ
	(2) Barron's Dictionary	of Medical Terms for the	į.		
	Non-Medical Reader, 7	7th edition, Rothenberg and			
	Chapman, page 120.		1	1	Į
1	(3) Barron's Dictionary	of Medical Terms for the	1		
-	Non-Medical Reader, 7	th edition, Rothenberg and	1		
[	Chapman, page 420.	•	1		
F 730	Nurse Aide Peform Rev	view-12 hr/vr (n-Service	F 730		
SS=D	CFR(s): 483.35(d)(7)	,	1	1. Employee #13, #14, #6, #16	
	( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (		]	#15 provided mandatory 12-hou	ır
1.	§483.35(d)(7) Regular i	in-service education	l i	education	
	The facility must comple	ete a performance review		2. All current employees receive	d
	of every nurse aide at le	east once every 12		mandatory 12 hours of training t	
- 1	months, and must provi	de regular in-service	1 1	include education on abuse/neg	
10	education based on the	outcome of these	1	and dementia care.	
		ning must comply with the	† !	3. DON or designee will provide	
r	requirements of §483.9	fing musicomply with the		facility educator and HR on police	
	This REQUIREMENT is			regarding mandatory annual	"
	by:	s not met da evidenced	*	education for CNA staff.	
	Based on staff interview	y and employee record		4. DON'or designee will audit 10	10/
r	eview it was determine	ed the facility staff failed to	1 1	of all staff to ensure acquisition	
d	socument the annual tra	ining to include in		mandatory annual 12-hour	,
d	lementia and ahuse and	d neglect, for four of five		competency weekly times 4 wee	lea .
lo	CNA (certified nursing a	ssistant), (CNA # 13, #14,	] [	and monthly times 2 to ensure the	
#	6 and #16).	3331311(), (0147 # 13, #14,	i l		
"				the facility maintains standards of	)ı
7	he findings include:			necessary education. Any	İ
1.	no mangs made.		l l	identified issues will be	
77	he list of CNAs, employ	ed greater than and		immediately corrected. Results v	
				be reported to Quality Assurance	
	ear, was provided by As nember) #1, the adminis	SM (administrative staff		committee for analysis and revis	ion
1 "	norovimataly 12:20 = =	The list consists of all 20		x 3 months.	" E )
at of	PPIONITIALETY 12:30 P.M	. The list consisted of 38		<ol><li>Date of compliance will be</li></ol>	186
1 4-	aining rooseds was	es. Five CNA employee			
1172	aining records were rev 15, #6 and #16.	iewed, CNA #13, #14,	ļ		1/19/2
#1	15, #6 and #16.				
		i			1

STATEMENT AND PLAN (	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		49 <b>52</b> 27	B. WING	B, WING				
	PROVIDER OR SUPPLIER  RT REHABILITATION AND	NURSING CENTER	ST/ 730	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION			
the single state of the si	reviews and document educations for CNAs to dementia.  On 10/4/2021 at 4:17 p #3, the quality assuran preventionist nurse, profrom the following date performed: 4/29/2021 - dementia a training 4/29/2021 - abuse and 6/10/2021 - abuse and 10/1/	tation of the required of include abuse and of include abuse and of include abuse and of include abuse and of include abuse and of include abuse and of include abuse and the training documents and the training that was and Alzheimer's disease of including include training are glect training are glect training. Of have any file on CNA deets provided with each are that CNA #14, CNA #6 any of these trainings. In an abuse and neglect of the required of she's been doing tely has not been timing of the required of she's been doing tely has not been timing of the required of	F 730					

PRINTED: 10/19/2021 FORM APPROVED

	TO TOT MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		495227	8. WING_			C 0/05/2021
	PROVIDER OR SUPPLIER ORT REHABILITATION AND	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	_ 1 10	1105/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	9E	(X5) COMPLETION DATE
F 745 SS=D SS=D SS=D SS=D SS=D SS=D SS=D SS=	training requirements. have all of mandatory istaff."  A request was made for training requirements or An email was received of nursing, on 10/5/202 documented they do not mandatory training requirements of mandatory training requirements of mandatory training requiremented in part, "4. training/orientation programments of abuse, stress handling verbally or phyresident behavior."  ASM (administrative stated director of nursing, was concern on 10/5/2021 at Provision of Medically Received to the facility medically-related social smaintain the highest practical psychosocial well-bethis REQUIREMENT is by: Based on observation, research	RN #4 stated, "We don't trainings completed for all or the policy on CNA in 10/5/2021 at 11:30 a.m. from ASM #2, the director 1 at 3:10 p.m. that in thave a policy related to direments for CNAs.  se Prevention Program" Required staff rams that include such ion, identification and is management and sically aggressive  If member) #2, the made aware of the above in:58 p.m. elated Social Service  services to attain or obticable physical, mentalling of each resident, not met as evidenced esident interview, staff int review, clinical record of a complaint mined that the facility dically related social esidents in the survey	F 745			

STATEMENT AND PLAN (	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTIONS	ON	(X3) DAT	E SURVEY IPLETED
		495227	B. WING				C
	PROVIDER OR SUPPLIER	O NURSING CENTER		STREET ADDRESS 7300 FOREST AV RICHMOND, VA		1 10	)/05/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EAC	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BI S-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
in section of the sec	The facility staff failed follow up following Res restrained on 5/6/21, fa services follow-up to R transferred to another is social services follow-up angry outburst, during hand by punching a horn the findings include:  1. The facility staff failed follow up following Resi restrained on 5/6/21.  Resident #502 was admat/27/16, and most recer with diagnoses including and arthritis. She was dien 6/12/21. On the most data set), a quarterly as assessment reference of the following restrained one out of 15 on mental status). She was coded as bein mpaired for making daily cored one out of 15 on mental status). She was laced in physical restraineriod.  The facility staff failed for making daily cored one out of 15 on mental status. She was coded as bein mpaired for making daily cored one out of 15 on mental status. She was laced in physical restraineriod.  The facility staff failed for making daily cored one out of 15 on mental status. She was assessment with the following profession of the following profession attached to the facility of clothing. The wind a skin assessment with the grity issues noted."	to provide psychosocial sident #502 being physically alled to provide social desident #40's request to be facility and failed to provide ap following Resident #91's which he fractured his le in his wall.  In the provide psychosocial dent #502 being physically white the facility on a control of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of facility of the facility of facility of facility of facility of facility of the facility of facilit	F7	facility services incident 4. DON of all re reportal social s follow-u weekly times 2 maintair well-beil resident be imme will be re Assuran and revi	or designee will provide social worker with educating follow-up care and its following reportable its or altercations.  If or designee will audit 10 esident altercations or facilities incidents to ensure services is providing up and ongoing support times 4 weeks and mont to ensure that the facility is the psychosocial ing and support of its. Any identified issues is ediately corrected. Resulteported to Quality ince committee for analysision x 3 months.  Of compliance will be	owill	11/19/2./

	-141-	TO T OIT MEDICARE &	MEDICAID SERVICES					OWR IA	<u>IO. 0938-0391</u>
		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILOIN		STRUCTION			E SURVEY PLETED
		i	495227	B, WING _				10	C 0/05/2021
NAN	AE OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE	ZIP CODE		
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WE	SIPO	RT REHABILITATION AND	NURSING CENTER			OND, VA 23226			
l (x	4) ID	SUMMARY STA	NTEMENT OF DEFICIENCIES	l ID	1	· · · · · · · · · · · · · · · · · · ·	AN OF CORRECTION		(X5)
PR	EFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	ļ	(EACH CORRECTIV	E ACTION SHOULD BE		COMPLETION
'	AG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	-		D TO THE APPROPRIA CIENCY)	TE	DATE
	-	<u> </u>	<u> </u>	T.					<del> </del>
F	745	Continued From page	229	F 74	اء				
			y to the state agency on	F /*	13				
ļi	- 1	5/11/21 revealed, in pa	art: "On [5/6/21] staff		Į				
		observed [Resident #5	02)'s wristband was		- 1				
	İ		via a string-like material.						
			[Resident #502] noted to						
	}		sidents on unit interviewed						i
	ı	to ascertain feelings of							]
			sidents on unit assessed		-				
			observed. Psychosocial						
		weil-being will continue Social Worker."	to be followed up on by		1				
		SOCIEI TTOINEI,							
		Further review of Resid	lent #502's clinical record						
			of a psychosocial follow up	1	-				1
		by the social worker.							
		A review of Perident #F	502's comprehensive care	1					
	- 1	olan dated 5/11/16 and	updated 6/26/16 revealed,	1					
		n part: "At risk for chan		1			24		
		diagnosis of dementia,	•		1				
•			nvironmental changes that	1	i	10.6			1 1
	r	may precipitate change	in mood." The review		1				1
			arding the resident being	1					
	ŀ	placed in physical restra	aints.						
	1	On 9/30/21 at 10:27 a.m	ASM (administrative						
		staff member) #4, the m		1					i
		nterviewed. ASM #4 sta						i	
		502 for many years. He			1				! I
		amiliar with the circums							
		Resident #502's being ti							
			rhaps a supervisor were						
	l te	erminated as a result.							
		on 10/4/21 at 10:34 a.m	OSM (other staff					]	
	l m	nember) #4, the director	r of social services, was						
		terviewed. She stated :							
		orking at the facility for	-						
			ak to anything that was						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/19/2021 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 495227 NAME OF PROVIDER OR SUPPLIER 10/05/2021 STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE WESTPORT REHABILITATION AND NURSING CENTER RICHMOND, VA 23226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 745 Continued From page 230 F 745 or was not done prior to her arrival at the facility. When asked if the social worker should perform a psychosocial assessment of a resident following an incident in which the resident was tied to her bed by her wrist, OSM #4 stated, "Absolutely. No question." On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was Interviewed. When asked if a social services psychosocial assessment had been performed on Resident #502 following the incident in which she was tied to her bed, ASM #2 stated, "There was none." When asked if this should have been done, ASM #2 stated, "Yes. Of course." On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. When asked about the social worker's role in psychosocial assessments for residents, he stated the social worker is responsible for going to interview the resident and see if any new interventions need to be put in place following any sort of unusual event. He stated the social worker should have followed up following Resident #502's being tied to her bed. A review of the facility document, "Social Worker Job Description," revealed, in part: "Performs resident/family evaluations and histories. Provides psychosocial support through individual, group, or family counseling, as needs dictate. Continuously reviews service area for group support needs and opportunities." No further information was provided prior to exit. Complaint Deficiency

PRINTED: 10/19/2021 FORM APPROVED

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		(X3) DATE	D. 0938-039 ESURVEY PLETED
		495227	B. WING				C
	PROVIDER OR SUPPLIER ORT REHABILITATION AND	NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			10/05/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIA		(XS) COMPLETION DATE
i i i i i i i i i i i i i i i i i i i	2. The facility staff faile services follow-up to R transferred to another in transferred to another in transferred to another in transferred to another in transferred to another in transferred to another in transferred to another in transferred to another in transferred to another in transferred to another in transferred to another in transferred in the facility. He was coded in the facility in the was coded in the facility in the was observed standard front of the facility. He was and he was smoking.  On 9/28/21 at 10:10 a.m interviewed. He stated a self-gament of the facility in the was different in the facility in the was smoking. The stated in the facility in the was smoking of the facility in the was smoking of the facility in the was smoking of the facility in the	ed to provide social lesident #40's request to be facility.  Illted to the facility on a including multiple and drug abuse. On the mum data set), a quarterly to (assessment reference as having no cognitive daily decisions, having the BIMS (brief interview ately 10:00 a.m., Resident ding on the sidewalk in ras unsupervised by staff,  I., Resident #40 was feer the observation on on the sidewalk smoking, if member) #1, the garettes. He stated he ent facility, and the on the transfer.  I's clinical record ogress notes:  I.m., Social Services rker) and Administrator date. Resident with the sidewalk, and allow-up with his mother	F 745				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495227	B, WING			C 0/05/2021
	PROVIDER OR SUPPLIER  PRT REHABILITATION AND	NURSING CENTER	730	REET ADDRESS, CITY, STATE, ZIP CODE 0 FOREST AVE CHMOND, VA 23226		0/03/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(XS) COMPLETION DATE
in present the pre	has been emailed to [r coordinator at local factor of the coordinator at local factor of the coordinator at local factor of the coordinator at local factor of the coordinator at local factor of the coordinate of the coordinate of the coordinate of the coordinate of the coordinate to assist in factor of the coordinate to follow and a coordinate to follow and a coordinate to follow and a coordinate to follow and a coordinate to follow and a coordinate to follow and a coordinate to follow and a coordinate to follow and a coordinate to follow and a coordinate to follow and a coordinate to follow and a coordinate to follow and a coordinate to follow and a coordinate of two notes no longer works.  A review of Resident #44 coordinate to physical community due to physical community due to physical community due to physical community due to physical community at the coordinate coordinate to the coordinate coordinate to the coordinate coordinate to the coordinate coordinate to the facility when the coordinate coordinate to the facility when the coordinate coordinate to the facility when the facility whe	aame of admissions alility]."  3 a.m.) Social Services Meeting held with writer, ble party), administrator iscuss resident's long term ent's physical and well as the appropriate I needs. Resident stressed I living options outside of greeable to referrals being in the area. Referrals to ur local facilities]. Will ilitating transfer and will ssist with needs as they member who wrote these rks at the facility.] ent #40's clinical record further follow-up by the  0's comprehensive care ealed, in part: "Patient for discharge to the cal care needsProvide upon requestReassess I for discharge as  ASM (administrative ministrator, was ns. ASM #1 stated when within the last three ing the no smoking sult, Resident #40	F 745			

PRINTED: 10/19/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL(A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING 495227 10/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE WESTPORT REHABILITATION AND NURSING CENTER RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 745 | Continued From page 233 F 745 social worker and the resident's mother. He stated the resident and his mother agreed to a facility, then changed their minds. ASM #1 stated, "I am still going through that process to get them to agree on a facility." He stated he is working on a group home placement for the resident. When asked about any efforts since 7/29/21, he stated he had evidence of ongoing conversations and facility efforts, and would provide those to the survey team. Prior to exit, ASM #1 did not provide any additional information regarding follow-up on alternate placement for Resident #40. A review of the facility document, "Social Worker Job Description," revealed, in part: "Works with the resident, family, and other members of the health care team to formulate a discharge plan that provides the resident services in the appropriate post-acute care setting, Gathers and assesses information regarding the resident's physical needs, mental status, family support system, financial resources, and available community and governmental resources. Employs assessment to develop a comprehensive case management plan that will address the needs identified. Determines specific objectives, goals, and measures that are designed to meet the client's needs that have been identified through assessment. The plan will be action- oriented and time-specific including collaboration with utilization management to manage length of stay. Maintains contact with the resident's third-party payers to ensure the most cost-effective plan of care is being carried out and appropriate in network providers are being utilized Provides information about resources and options available in the community and coordinates service delivery. Interprets resident/family needs

		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	· -		E SURVEY
		i				<del>_</del>		С
<u> </u>			495227	B. WING _			10	/05/2021
l		PROVIDER OR SUPPLIER  ORT REHABILITATION AND	NURSING CENTER		STREET ADDRESS, CITY, 7300 FOREST AVE RICHMOND, VA 2322	• • • • • • • • • • • • • • • • • • • •		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORE	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD E RENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
75	79%	and provides informatic availability and limitatic and addresses concernincluding service gaps implements discharge referral and coordination. No further information of Complaint Deficiency.  3. The facility staff failer services follow-up follow outburst, during which in punching a hole in his with the content of the court of t	on concerning the ons of resources. Educates ins with service delivery and access issues. plan through service on activities."  was provided prior to exit.  d to provide social wing Resident #91's angry in a fractured his hand by wall.  tted to the facility on ently readmitted on including diabetes and in the most recent MDS ignificant change including diabetes and in the most recent making daily in 15 out of 15 on the mental status).	F 74	45	DEPICIENCY		
	i i	"Resident alert and verba at the beginning of the standard witnessed punching his land of anger. Resident composwelling, pain, and discondition." Further review of Resider	al, observed to be angry hift. Resident was eft hand on the walt out lains of left hand mfort on ROM (range of					
	, jr	evealed an X-ray perform confirmed Resident #91's	med on 6/21/21					1

STATEMENT AND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY DMPLETED
		495227	B, WING			C
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226		10/05/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 745	Continued From page	235	F 7	45		
		dent #91's clinical record of social services follow-up ent.				
	plan dated 12/24/20 ar	91's comprehensive care nd updated 8/27/21 falled to ted to the 6/21/21 incident.		-		
	interviewed. She stated working at the facility for she could not speak to not done prior to her are asked if the social work psychosocial assessment incident in which the by punching his wall followed.	or of social services, was I she had only been or three days. She stated anything that was or was rival at the facility. When				
	Resident #91 following	irector of nursing, was ad if a social services nt had been performed on the incident in which he unching a wall, she stated: n asked if this should				\$20
p s to	o interview the resident nterventions need to be ort of unusual event. He	ned of these concerns. ocial worker's role in nts for residents, he is responsible for going				

CTATCAICAG		I SERVICES			OMB NO. 0938-0391
AND PLAN (	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
<u> </u>		495227	B. WING		C 10/05/2024
NAME OF	PROVIDER OR SUPPLIER		<del></del>	STREET ADDRESS, CITY, STATE, ZIP CODE	10/05/2021
WESTER	IDT DEMARK ITATION			7300 FOREST AVE	
MESIFO	PRT REHABILITATION AND	NURSING CENTER		RICHMOND, VA 23226	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	211
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 745	Continued From page	236	F 745		
	angry outburst and har		1 175	)	
	No further information	was provided prior to exit.			
	Complaint Deficiency				
F 761	Label/Store Drugs and	Biologicals	F 761	1. The facility discarded all exp	nired
SS=D	CFR(s): 483,45(g)(h)(1	)(2)	-	Intravenous medications from	
	8483 (5(a) Labelina of	Division and Dialastics		medication room and all expire	ed
1	§483.45(g) Labeling of	urugs and Biologicals sed in the facility must be	1 1	medications from the medicati	
	labeled in accordance v	with currently accepted		carts.	
	professional principles,	and include the	1	All medication rooms and	
- 1	appropriate accessory a	and cautionary		medication carts were inspecte	ed to
- 1	instructions, and the exp	oiration date when	1	ensure no expired medications	;
	applicable.			remained for possible use. 3. DON or designee will provid	
- 1	§483.45(h) Storage of D	rugs and Biologicals		education to facility nursing sta policy for medication storage to	aff on
1	§483.45(h)(1) In accorda	ance with State and	1 1	include handling of expired	[
	Federal laws, the facility	must store all drugs and		medications.	
1	biologicals in locked con	partments under proper		<ol> <li>DON or designee will audit a</li> </ol>	
- 10	emperature controls, an	d permit only authorized	1 1	medication rooms and medicat	
F	personnel to have acces	s to the keys,	1 1	carts to ascertain that there are expired medications or multido	
8	483.45(h)(2) The facility	must provide separately		bottle medications available for	use
140	ocked, permanently affix	ed compartments for		and that these medications are	
S	torage of controlled drug	gs listed in Schedule II of	1 1	discarded according to the	
į ti	he Comprehensive Drug	Abuse Prevention and	1 1	manufacturer's suggested date	
10	Control Act of 1976 and o	other drugs subject to		disposal, weekly times 4 weeks	
	buse, except when the I		1	monthly times 2 to ensure that	the
p	ackage drug distribution	systems in which the	1	facility is in accordance with	,
h	oannly stored is minima e readily detected.	and a missing dose can		expiration dates as applicable.	Any
	his REQUIREMENT is	not met as avidenced		identified issues will be immedia corrected. Results will be repor-	ately 1//19/21
	A:	HOT HIEL OF CANADICED		to Quality Assurance committee	100
	Based on observation an	d staff interview. It was		analysis and revision x 3 month	
de	etermined the facility sta	ff failed had expired	i	5. Date of compliance will be	19.
		venous) fluids that were		and of softiplication will be	7

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ł							С	
Ĺ		495227	B, WIN	G	<del></del>		10/05/2021	
	PROVIDER OR SUPPLIER	NURSING CENTER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATÉMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PRE	FIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	and one of four medical medication room and water medication cart.  In the Wing two medically solution, Dextrose 5 were observed availabilities the bags expired "Sepone bag documented to 2021."  In the front half medical 10/5/2021, a bottle of Awas opened on 2/4/202 resident use. The expired 7 Daily Multivitamin was a use and had an expiration the bottle that read, "Bethe bottle that read, "Bethe bottle that read, "Bethe bottle that read, "Bethe bags of IV solution 9%Normal Saline. Each expiration date of "Aug 2 was interview was conducted in the control of the september) 2021" and expiration date of "Aug 2 was interview was conducted in the control of the september) 2021 and expiration date of "Aug 2 was interview was conducted in the control of the september) 2021 at 8:26 a.m. The seviewed with LPN #8. Vere available for use, L	e of two medication rooms ation carts, Wing Two Wing Two Front hall  ation room, three bags of % with .9%Normal Saline le for resident use. Two of (September) 2021" and he expiration date of "Aug tion cart for Wing two on spinn 325 mg (milligrams) 21 and available for ration date on the bottle 7/2021." A bottle of One open, available for resident on date documented on est by: 11/20."  of the mediation room on at 8:15 a.m. There were n, Dextrose 5% with h bag was 1000 cc (cubic bags expired "Sep one bag documented the 2021."  cted with LPN (licensed unit manager, on the bags of IV fluids were when asked if the bags PN #8 stated, yes. When a these were intended for a facility, LPN #8 stated	F	761		19		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICARE &	MEDICAID SERVICES				O. 0938-039
STATEMENT AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A, BUILDING	E CONSTRUCTION		E SURVEY IPLETED
		495227	8. WING			C
	PROVIDER OR SUPPLIER  DRT REHABILITATION AN	ID NURSING CENTER	7	STREET ADDRESS, CITY, STATE, ZIP COD 300 FOREST AVE NICHMOND, VA 23226		0/05/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 761	Continued From page	238	F 761			
	8:55 a.m. A bottle of A was opened on 2/4/20 the bottle documented bottle was three quart Daily Multivitamin was expiration date documerad, "Best by: 11/20." conducted with LPN # a.m. LPN #18 was aslabove. When asked if available for use, LPN asked the process for LPN #18 stated you hadose, right patient, right	ing two on 10/5/2021 at Aspirin 325 mg (milligrams) 221. The expiration date on d, "expired 7/2021." The ers full. A bottle of One copen and had an ented on the bottle that "An interview was 19 on 10/5/2021 at 9:00 and to look at the bottles these medications were #18 stated, yes. When administering mediations, are to check for the right at time and right and if the expiration date.				
	A copy of the facility po of medications and IV t 10/5/2021 at 11:30 a.m	ficy related to the storage liuids was requested on			•	
10	ASM (administrative sta director of nursing, was concern on 10/5/2021 a	made aware of the above				
3 ti	3:10 p.m. that the facilit	nail dated 10/5/2021 at y did not have a policy on ons and IV fluids that were				
F 770 L	No further information was aboratory Services CFR(s): 483.50(a)(1)(i)	as provided prior to exit.	F 770	, # 10		- * - ** - **
§	483.50(a) Laboratory S	Services.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			10/	05/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER	1	7:	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE LICHMOND, VA 23226	1 101	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 770	§483.50(a)(1) The facilibration and timeliness of the (i) If the facility provid services, the services requirements for labor of this chapter.  This REQUIREMENT by: Based on observation interview, clinical recodocument review it was facility staff failed to pservices for one of 84 sample, Resident #13 laboratory supplies panot available for use rooms observed. Wind 1. The facility staff failed to pservices for one of 84 sample, Resident #13 laboratory supplies panot available for use rooms observed. Wind 1. The facility staff failed to pservices for one of 84 sample, Resident #13 laboratory supplies panot available for use rooms observed. Wind 1. The facility staff failed to pservice on 9/28/202 from laboratory on 10 with facility staff.  2. A box of Hemocculibral full, with an expirational available for resident full, with an expirational available for resident full. The findings include:  1. Resident #13 was diagnoses that include the services to the facility staff.	cility must provide or obtain meet the needs of its is responsible for the quality services.  es its own laboratory must meet the applicable ratories specified in part 493 is not met as evidenced in, resident interview, staff ord review and facility as determined that the rovide timely laboratory residents in the survey and failed to ensure ast their expiration date were in one of two medication g two medication room.	F	770	1. Resident #13 still resides in the facinesults were received and provided to for recommendations during inspectio 2. All residents receiving laboratory studies are at risk. 3. DON or designee will ensure timely follow up on laboratory results and the expiration dates on supplies for in-houprovided laboratory services are discarded by manufacturers suggested date of disposal. 4. DON or designee will audit 10% of labs ordered to ascertain that the resulare reported in a timely manner and the all in-house lab supplies are not expirated according to the manufacturer's suggested date of disposal, weekly tin 4 weeks and monthly times 2 to ensure that the facility provides timeliness of laboratory services and that the in-houprovided laboratory services meet applicable requirements. Any identificial issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	MD n.  t use n All lts hat ed use	11921

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICARE &	MEDICAID SERVICES				C	OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION			(X3) DATE : COMPI	
1		İ				-	C	
		495227	B. WING_				10/0	05/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET AODRESS,	CITY, STATE, ZIP CODE			
WESTPO	RT REHABILITATION AN	D NURSING CENTER		7300 FOREST AVE RICHMOND, VA	23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	VIDER'S PLAN OF COR CORRECTIVE ACTION S EFERENCED TO THE A DEFICIENCY)	SHOULD BE		(XS) COMPLETION DATE
	Resident #13's most of set), a quarterly asses (assessment reference Resident #13 as scori assessment for menta of 0 - 15, 15- being condaily decisions. Section as being frequently incomplete of the property of the propert	nary tract infections (2), ecent MDS (minimum data ssment with an ARD e date) of 7/1/2021, coded ng a 15 on the staff at status (BIMS) of a score gnitively intact for making on H coded Resident #13 continent of urine.  Eximately 2:00 p.m., an ed with Resident #13, and they currently had a Resident #13 stated that sated for the infection itting for the results of the e back from the lab #13 stated that there was not their results of any lity and they were not sure as.  Eximately 2:30 p.m., a follow uncted with Resident #13, at they had not gotten any ample sent to the lab the of felt like they still had a secause they had burning ent #13 stated that they are cause they had burning ent #13 stated that they are cause they had burning ent #13 stated that they are cause that they had our come back that day.  Fresident #13  A/C&S (urinalysis with	F 77			Eq.		
	the progress notes for	Resident #13 documented				- 5		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		495227	B. WING		10/05/2021
	PROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
	in part, "9/25/2021 17:37 (5:3 Physician/Practitioner had complaints of urin An order was written fi collected tomorrow an culture" "9/26/2021 15:15 (3:1	7 p.m.) Progress noteShe also ary urgency and frequency. or a straight cath UA d to send for urinalysis and 5 p.m.) Nursing/Clinical. llect urine via (by) straight UTI." I a.m.) Nursing/Clinical. ollect urine via straight cath hick discharge in vaginal to so tense during staff unable to obtain a  a.m.) Nursing/Clinical. LY 9/27/21: Resident urine t stated she has be having ding resident results ollow up with Md (medical p.m.) Progress NoteGU tive) urinary pressure," p.m.) S results pending." p.m.) S results pending." p.m.) Nursing/Clinical, lame of laboratory] and	F 77		
s ti n re	ent off for testing, the lands ample. NP (nurse protified of this matter. Nesident states that the corredominantly as it was			VDH/C	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION		(X3) DATE	SURVEY PLETED
		495227	B. WING			l	C
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIE 7300 FOREST AVE RICHMOND, VA 23226	P CODE	10/	05/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	STEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA		(X5) COMPLETION DATE
i de la companya de l	POC (plan of care) per Resident notified of sathem."  On 10/4/2021 at 11:36 conducted with LPN (ii LPN #8 stated that uring collected on the night is #8 stated that they had they used for testing. It that Resident #13's uring located out of state. LF collected the speciment took the specimen took the specimen took the specimen took the specimen for delivery to the LPN #8 stated that they frame for delivery to the LPN #10 stated that they used for testing. LF facility preferred them toof state that Resident #10 stated that they used for testing. LF facility preferred them toof state that Resident #10 stated that they used for testing. LF facility preferred them toof state that Resident #10 stated that they used for testing. LF why. LPN #13 stated they tresults from the out-between the second that they was only one log in that and it was very different was only one log in that and get results back time and get results back time.	a.m., an interview was censed practical nurse) #8. alysis specimens were shift in the morning. LPN I two lab companies that LPN #8 stated that the lab he specimen went to was PN #8 stated that they and the nurse supervisor le [Name of delivery fay to ship it to the lab. I were not sure of the time of the lab. I was an interview was PN #10 stated that the lab he specimen went to was PN #10 stated that the lab. I was the lab to manager. I was the lab that was out lad it was very difficult to lab that was out lad it was very difficult to lab the lab the cause they conto the website until the lab. LPN #10 stated that the much easier to work with lady. LPN #10 stated that	F 770				
la W L	ab by [Name of delivery ras normally a wait to go PN #10 stated that Res	et results of the testing.					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICARE &	MEDICAID SERVICES				O. 0938-039
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
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NAME OF F	PROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CO	<del> </del>	0/05/2021
WESTPO	RT REHABILITATION ANI	D NURSING CENTER		7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE E APPROPRIATE	(XS) COMPLETION DATE
1 (t) iii h	results at that point. L. would contact the lab specimen sent out on On 10/5/2021 at approrequest was made to Amember) #2, the direct policy on laboratory set The facility policy "Ava Diagnostic" dated Decepart, "Clinical laborator meet the needs of our our facilityOur facility on-premises diagnostic following tests may be All others are forwarded specified by facility polica. Routine urinallysis On 10/4/2021 at approxical daministrator and ASM were made aware of the No further information was efferences:  I. Chronic obstructive properties that mean lead to shortness formation was obtained inters://www.nlm.nih.gov.	PN #10 stated that they to check the status of the 9/28/2021.  eximately 9:15 a.m., a ASM (administrative staff tor of nursing for the facility ervices.  Illability of Services, ember 2009 documented in y and radiology services to residents are provided by does not provide a services. Only the conducted by the facility. In the lab service cy.  Indicated 4:30 p.m., ASM mber) #1, the #2, the director of nursing a concern.  In a provided prior to exit.  In a pulmonary disease makes it difficult to breath as of breath. This difform the website:  In a from	F 770			
a	nd extra water. It includ reters, a bladder, and a	les two kidneys, two				

PRINTED: 10/19/2021 FORM APPROVED

STATEMENT AND PLAN (	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE O	CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY IPLETED
		495227	B. WING		44	C 0/05/2021
1	PROVIDER OR SUPPLIER		730	EET ADDRESS, CITY, STATE, ZIP CODE 0 FOREST AVE HMOND, VA 23226		1103/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
A dia sir con A din fin	infections (UTIs) are the type of infection in the was obtained from the https://vsearch.nlm.nih.meta?v%3Aproject=memediineplus-bundle&quin  2. Observation was man on Wing two on 10/5/20 Hemoccult sildes (1), at found with an expiration An interview was condupractical nurse) #8, the 10/5/2021 at 8:26 a.m., review the box of Hemoc of the slides were expired When asked if they were 8 stated, "Yes."  According to applicable in a 493.1252 Standard: Teastruments, reagents, materials, calibration mal pupplies must not be use exceeded their expiration are of substandard quasses.	the second most common body. This information website: gov/vivisimo/cgi-bin/query-difineplus&v%3Asources=tery=urinary+tract+infection de of the medication room to the second sec	F 770			
Re	eferences:					

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCT	ION		TE SURVEY
			1.00.00				С
		495227	B. WING			10	0/05/2021
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRE	SS, CITY, STATE, ZIP CODE		
WESTPO	RT REHABILITATION ANI	D MUDGING CENTED		7300 FOREST	AVE		
	THE REMAINS THE PROPERTY OF TH	D NUKSING CENTER		RICHMOND, V	VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 770	Continued From page	245	F	70			
	(1) Tests for fecal occustool that is not visible usually less than 50 m of stool, this information	alt blood detect blood in the					
F 812 SS=E		ore/Prepare/Serve-Sanitary )	F 8	expirat	lity discarded all milk wi ion date of 9/24/2021.	th the	
	§483,60(i) Food safety The facility must -	requirements.	0	3. DON expirati	esidents are at risk.  I or designee will ensure ion dates for all food iter	ทร	
	state or local authorities (i) This may include for from local producers, so and local laws or regula (ii) This provision does facilities from using pro- gardens, subject to con- safe growing and food- (iii) This provision does from consuming foods r  §483.60(i)(2) - Store, pr serve food in accordance standards for food servic This REQUIREMENT is by: Based on staff interview eview, it was determine naintain food in a safe a	d satisfactory by federal, s. di items obtained directly ubject to applicable State ations.  not prohibit or prevent duce grown in facility inpliance with applicable handling practices.  not preclude residents not procured by the facility.  epare, distribute and se with professional ce safety.  In not met as evidenced and facility document at the facility staff failed and sanitary manner.  Inopened with an 1 and one-half of a gallon piration date of 9/24/21		sugges 4. DON refriger the pro- to the n date of weeks a ensure- and sto profess service will be in Results Assurar and revi	carded by manufacturer stion date of disposal. I or designee will audit a rated items to ascertain duct is not expired acconanufacturer's suggested disposal, weekly times and monthly times 2 to that the facility maintainers food in accordance ional standards for food safety. Any identified is mmediately corrected. Will be reported to Quance committee for analy ision x 3 months. of compliance will be	all that rding d 4 s s with ssues	1912

STATEMENT AND PLAN (	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495227	B, WING			C
	PROVIDER OR SUPPLIER	NURSING CENTER	7300	EET ADDRESS, CITY, STATE, ZIP CODE D FOREST AVE HMOND, VA 23226	1110	0/05/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
F 812	Continued From page	246	F 812			
	a gallon of whole milk to expiration date of 9/24/ of whole milk with an exwere found.  An interview was condu. AM with OSM (other state) When asked the expiral stated, "Yes, the openedate of 9/24/21 will get were an unopened gallowould discard it now." Neshown the gallon of whole shown the gallon of whole was the same that the same tha	kitchen. In the refrigerator unopened with an (21 and one-half of a gallon xpiration date of 9/24/21 ucted on 9/28/21 at 11:10 aff member) #1, the chef. tion for milk, OSM #1 d whole milk with best by discarded on 9/30/21. If it on with date of 9/24/21, I When OSM #1, was				
a constant of the constant of	AM with OSM #2, the diasked about the expiration whole milk with a date stated, "No, it should be now."  On 9/28/21 at 12:30 PM, acility's "Food Receiving ated 10/17.  The facility's "Food Receiving ated 10/17, which document to the refrigerator and dated ("use by" date).	on for the one half gallon of 9/24/21, OSM #2 discarded. I will do it  OSM #2 provided the gand Storage" policy  iving and Storage" policy ments in part, "Alf foods will be covered, labeled				

		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
			495227	B, WING				C
N/	ME OF	PROVIDER OR SUPPLIER		1 - 1 - 1 - 1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	0/05/2021
w	ESTPO	PRT REHABILITATION AND	NURSING CENTER		73	300 FOREST AVE IICHMOND, VA 23226		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	F 812	director of nursing wer findings.  No further information Use of Outside Resour	e made aware of the above was provided prior to exit. ces	F 8	312	Facility obtained active contra	nct	
	SS=E	S483.70(g) Use of outs §483.70(g) Use of outs §483.70(g) Use of outs §483.70(g)(1) If the fac qualified professional p service to be provided to must have that service person or agency outsid arrangement described Act or an agreement de (2) of this section.  §483.70(g)(2) Arrangem section 1861(w) of the Apertaining to services fur resources must specify assumes responsibility for the factorial of the factorial	ide resources.  ility does not employ a erson to furnish a specific by the facility, the facility furnished to residents by a de the facility under an in section 1861(w) of the scribed in paragraph (g)  ments as described in act or agreements rnished by outside. in writing that the facility for- at meet professional is that apply to services in such a facility; services. not met as evidenced and facility document d the facility staff failed to greement for the facility.  current written contracts ies being utilized for ed to ensure new when undergoing a	F8	140	<ol> <li>Facility obtained active contra with Dialysis provider.</li> <li>All Dialysis residents are at ris</li> <li>DON or designee will ensure dialysis contracts will be maintain facility.</li> <li>DON or designee will audit 10 of dialysis residents to ascertain that there is a contract with the dialysis provider from which they receive services, weekly times 4 weeks and monthly times 2 to ensure that the facility maintains current written contracts with dialysis companies being utilized residents: Any identified issues to be immediately corrected. Result will be reported to Quality Assurance committee for analysis and revision x 3 months.</li> <li>Date of compliance will be</li> </ol>	sk. that ned % , by will -	11/19/21

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CO	INSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495227	8, WING			C 40/05/2024			
1	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE MOND, VA 23226		10/05/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	YEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE			
F 840	Continued From page The findings include:	248	F	840					
	9/28/21, a request was contracts or agreemen On 9/29/21, a review of evidenced contracts day one dialysis company.  On 10/4/21 at approximate (administrative staff meadministrator, brought in including the facility policy documenting "Veadialysis".  On 10/4/21 at 1:51 PM administrator, brought pand stated, ""We have a she dialysis companies. Contracts signed. I have a she dialysis companies. Contracts signed. I have a she dialysis companies. Contracts signed. I have a she dialysis companies. Contracts signed. I have a she cought in January 2020, contracts signed. I have a she contracts was before I came.  On 10/4/21 at 4:30 PM, conference, when asked.	ts to be provided.  If the dialysis contracts sted 2009 and 2013 for the sted 2009 and 2013 for the sted 2009 and 2013 for the sted 2009 and 2013 for the sted 2009 and 2013 for the sted 2009 and 2013 for the sted 2009 and 2013 for the sted 2009 and 2014 for the sted 2014 for the st						3.5	

PRINTED: 10/19/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING\_ C 495227 B. WING 10/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE **WESTPORT REHABILITATION AND NURSING CENTER** RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) MPLETION DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY Continued From page 249 F 840 A request was made on 10/5/21 at approximately 9:00 AM for any policy regarding facility contracts with outside resources, none was provided. On 10/4/21 at 4:50 PM, ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above findings. 1. Residents #111 and #158 remain No further information was provided prior to exit. in the facility and are a member of F 842 Resident Records - Identifiable Information F 842 PACE services. Physician's CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) documentation was obtained and added to their medical records. §483.20(f)(5) Resident-identifiable information. All PACE residents are at risk. (i) A facility may not release information that is The Center coordinated with PACE resident-identifiable to the public. providers to obtain documentation (ii) The facility may release information that is missing from medical records. resident-identifiable to an agent only in 3. DON or designee will educate all accordance with a contract under which the agent PACE providers that progress agrees not to use or disclose the information notes should be included in the except to the extent the facility itself is permitted chart at the time of each visit. to do so. 4. DON or designee will audit 10% of PACE residents to ascertain that §483.70(i) Medical records. progress notes are included in the §483.70(i)(1) In accordance with accepted professional standards and practices, the facility medical chart weekly times 4 must maintain medical records on each resident weeks and monthly times 2 to ensure that the facility maintains a that are-(i) Complete; complete, accurately documented. (ii) Accurately documented; readily accessible and (iii) Readily accessible; and systematically organized medical (iv) Systematically organized record. Any identified issues will be immediately corrected. Results wili §483.70(i)(2) The facility must keep confidential be reported to Quality Assurance all information contained in the resident's records, committee for analysis and revision regardless of the form or storage method of the x 3 months.

records, except when release is-

(i) To the individual, or their resident

5. Date of compliance will be

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495227	B. WING_			C 10/05/2021		
	PROVIDER OR SUPPLIER	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 7300 FOREST AVE RICHMOND, VA 23226	DE	10/03/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B APPROPRIA			
	(ii) Required by Law; (iii) For treatment, pay, operations, as permitte with 45 CFR 164.506; (iv) For public health a neglect, or domestic vi activities, judicial and a law enforcement purpo- purposes, research pur medical examiners, fur a serious threat to heal by and in compliance w §483.70(i)(3) The facilit record information again unauthorized use. §483.70(i)(4) Medical refor- (i) The period of time re (ii) Five years from the there is no requirement (iii) For a minor, 3 years legal age under State la §483.70(i)(5) The medic (i) Sufficient information (ii) A record of the reside	ment, or health care ed by and in compliance of civities, reporting of abuse, olence, health oversight administrative proceedings, uses, organ donation proses, or to coroners, and to avert of the or safety as permitted with 45 CFR 164.512.  By must safeguard medical anst loss, destruction, or ecords must be retained equired by State law; or date of discharge when in State law; or after a resident reaches and record must containto identify the resident; ent's assessments; plan of care and services readmission screening luations and ed by the State; and other licensed notes; and y and other diagnostic	F8	142				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
1		495227	B. WING		С	
1	PROVIDER OR SUPPLIER		S1   73	IREET ADDRESS, CITY, STATE, ZIP CODE 100 FOREST AVE ICHMOND, VA 23226	10/05/2021	1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	REMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		ETION
	by: Based on staff intervies and clinical record for two clinical record for two clinical record for two clinical record for two clinical records.  The facility staff failed to note in Resident #111's clinical records.  The findings include:  1. Resident #111 was a 5/24/21. Resident #111 were not limited to diab anxiety disorder. Resident #111 were not limited to diab anxiety disorder. Resident #11 revealed a nurse's note documented the resident proposition as a second for the review of Resident #11 revealed a nurse's note documented the resident grading Resident #11 for 9/30/21 at approximate administrative staff memoursing) provided a physical grading Resident #111 provided a physical regarding Resident #111 provided a physical grad	is not met as evidenced  ew, facility document review ew, it was determined that o maintain a complete of 84 residents in the ents #111 and #158.  Ito maintain a physician's is and Resident #158's  Indirect #158's  Indirect #158's  Indirect #111's quarterly is sment with an idate of 8/28/21, coded the severely impaired.  It's clinical record dated 9/6/21 that ant was transferred to the  Indirect #111's clinical record and documentation It's hospital transfer.  Indirect #111's clinical record and documentation It's hospital transfer.  Indirect #111's clinical record In documentation It's hospital transfer.  Indirect #111's clinical record It's hospital transfer.  Indirect #111's clinical record It's hospital transfer.  Indirect #111's clinical record It's hospital transfer.  Indirect #111's clinical record It's hospital transfer.  Indirect #111's clinical record It's hospital transfer.  Indirect #111's clinical record It's hospital transfer.  Indirect #111's clinical record It's hospital transfer.  Indirect #111's clinical record It's hospital transfer.  Indirect #111's clinical record It's hospital transfer.  Indirect #111's clinical record It's hospital transfer.  Indirect #111's clinical record It's hospital transfer.  Indirect #111's clinical record It's hospital transfer.	F 842			

A95227  ANNIE OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER REGIMENON, V. 23226  STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE REGIMENON, V. 23226  REGIMENON, V. 23226  F 842  Continued From page 252  conducted with ASM #2. ASM #2 stated the physician note dated 9/9/21 was not in Resident ##111's clinical record. ASM #2 stated she had to reach out to the physician to obtain the note that was kept in a fille in far facility.  On 10/4/21 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.  The facility policy titled, "Clinical Records Policy & Procedure" documented, "4. An accurate and complete clinical record shall be maintained for each resident #158 was admitted to the facility on 7/14/20. Resident #158's dinical record resident's cognition as severely impaired.  Review of Resident #158's clinical record revealed the residentwas transferred to the hospital on 9/3/21 due to abdominal pain.  Further review of Resident #158's clinical record falled to reveal physician so to actual pain.  Further review of Resident #158's chinical record falled to reveal physician's note dated 9/3/21' regarding Resident #158's obspital transfer.  On 9/30/21 at approximately 8.00 a.m., ASM (administrative staff member) #2 (the director of nursing) provided a physician's note dated 9/3/21' regarding Resident #158's obspital transfer.  The facility policy the provided a physician's note dated 9/3/21' regarding Resident #158's hospital transfer.  The facility policy the provided a physician's note dated 9/3/21' regarding Resident #158's hospital transfer.  The facility policy the provided a physician's note dated 9/3/21' regarding Resident #158's hospital transfer.  The facility policy the provided a physician's note dated 9/3/21' regarding Resident #158's hospital transfer.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		LE CONSTRUCTION		PLETEO
MANE OF PROVIDER OR SUPPLIER  WESTPORT REHABILITATION AND NURSING CENTER  REGULATORY OR LSC IDENTIFYING INFORMATION)  FROM PRIEFIX ISJAMANY STATEMENT OF DEFICIENCES (EACH DEPOSITY OF METRY AND PRIEFIX INCHIMOND, VA. 23228  FROM PRIEFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  FROM PRIEFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  FROM PRIEFIX TAG OR CONTROL OR DEFICIENCES (EACH DEPOSITY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  CONDUCTED AND THE APPROPRIATE DEFICIENCY  ON 10/4/21 at 11:25 a.m., ASIM (administrative staff member) #1 (the administrative staff member) #2 (the director of nursing) provided a physician documentation regarding Resident #158's clinical record falled to reveal physician documentation regarding Resident #158's botton commentation regarding Resident #158's botton commentation and the physician documentation applications and the physician documentation and the physician documentation and the physician followed the staff member) #2 (the director of nursing) provided a physician's hock detaetd #1212 the physician's hock detaetd #1212 the physician's hock detaetd #1212 the physician's hock detaetd #1212 the physician's hock detaetd #1212 the physician's hock detaetd #1212 the physician's hock detaetd		i	495227	B, WING		<u> </u>	1	_
WESTPORT REHABILITATION AND NURSING CENTER  (24) ID (24) ID (25) RECACH DEPRICIENCY MUST SEP PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 842  Conducted with ASM #2. ASM #2 stated the physician note dated 5/6/21 was not in Resident ##11's clinical record. ASM #2 stated she had to reach out to the physician to obtain the note that was kept in a file in her facility.  On 10/4/21 at 11':25 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.  The facility policy titled, "Clinical Records Policy & Procedure" documented, "4. An accurate and complete clinical record shall be maintained for each resident and shall include: e. Progress notes written at the time of each visit"  No further information was presented prior to exit.  2. Resident #158' sciagnoses included but were not limited to dementia, diabetes and muscie weakness, resident #169's quarterly minimum data set assessment with an assessment reference date of 9/2621, coded the resident's cognition as severely impaired, Review of Resident #158's clinical record revealed the resident was transferred to the hospital on 9/3/21 due to abdominal pain.  Further review of Resident #158's clinical record regarding Resident #158's clinical record failed to reveal physician's notourentation regarding Resident #158's clinical record failed to reveal physician's notourentation regarding Resident #168's hospital transfer.  On 9/30/21 at approximately 8:00 a.m., ASM (administrative staff member) #2 (the director of nursing) provided a physician's note dated 9/3/21	NAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
(PA) ID PRIERRY REGULATORY OR LSC IDENTIFYING INFORMATION)  FREST REGULATORY OR LSC IDENTIFYING INFORMATION)  F 842  Continued From page 252  conducted with ASM #2. ASM #2 stated the physician not bated 9/8/21 was not in Resident #111's clinical record. ASM #2 stated she had to reach out to the physician not bated 9/8/21 was not the Resident was kept in a file in her facility.  On 10/4/21 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.  The facility policy titled, "Clinical Records Policy & Procedure" documented, "4. An accurate and complete clinical record shall be maintained for each resident and shall include: e. Progress notes written at the time of each visit"  No further information was presented prior to exit.  2. Resident #158 was admitted to the facility on 7/14/20. Resident #158's diagnoses included but were not limited to demental, disbetes and muscle weakness. Resident #158's quarterly minimum data set assessment with an assessment reference date of 9/26/21, coded the resident's cognition as severely impaired.  Review of Resident #158's clinical record revealed the resident was transferred to the hospital on 9/3/21 due to abdominal pain.  Further review of Resident #158's clinical record failed to reveal physician documentation regarding Resident #158's hospital transfer.  On 9/3/0/21 at approximately 8:00 a.m., ASM (administrative staff member) #2 (the director of nursing) provided a physician's note dated 9/3/21						7300 FOREST AVE		,
PREFIX TAG  REACH DEPICIENCY OR LSC DENTIFYING INFORMATION)  F 842  Continued From page 252  conducted with ASM #2. ASM #2 stated the physician note dated 9/6/21 was not in Resident #11's clinical record. ASM #2 stated she had to reach out to the physician to obtain the note that was kept in a file in her facility.  On 10/4/21 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.  The facility policy titled, "Clinical Records Policy & Procedure" documented, "4. An accurate and complete clinical record shall be maintained for each resident and shall include: e. Progress notes written at the time of each visit"  No further information was presented prior to exit.  2. Resident #158's diagnoses included but were not limited to dementia, diabetes and muscle weakness. Resident #158's quarterly minimum data set assessment with an assessment reference date of 9/26/21, coded the resident's cognition as severely impaired.  Review of Resident #158's clinical record revealed the resident was transferred to the hospital on 9/3/21 due to abdominal pain.  Further review of Resident #158's clinical record failed to reveal physician documentation regarding Resident #158's hospital transfer.  On 9/30/21 at approximately 8:00 a.m., ASM (administrative staff member) #2 (the director of nursing) provided a physician's note dated 9/3/21	WESTPOR	RT REHABILITATION ANI	D NURSING CENTER		1	RICHMOND, VA 23226		
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	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING				SURVEY LETED
				G			C 10/05/2021	
	ROVIDER OR SUPPLIER	D NURSING CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PRE TA	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE		(X5) COMPLETION DATE
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